ADVISORY COUNCIL ON PRESCRIPTION DRUG MONITORING

DEPARTMENT OF PUBLIC HEALTH

COLUMBIA, MARYLAND 21044

JANUARY 9, 2009

9:34 a.m.

CHAIRMAN:

THE HONORABLE JOHN F. FADER, II, Chairman

Reported by:

Janet A. Brown, R.P.R.

P R O C E E D I N G S

(WHEREUPON, at 9:34 a.m., the meeting was commenced.)

JUDGE FADER: All right. Good morning. We have a Court Reporter taking down today what is being said. Because one of the things when I talked to the Secretary about this was that I want, and he wants, everyone to know what was said so that if any of the Legislature have any problems, or if any of our recollections are different than what somebody said and a concern that was expressed, that it'll be available.

Now, Janet Brown is as good a Court Reporter as there is. But sometimes she's used to working just in a courtroom. So if she says to you, give me your name again, and speak up, or whatever, she's doing what she needs to do in order to take down what you said.

Now, once she finishes writing this up, I'll have a hard copy. But the rest of it will be sent to everyone in electronic format for you to print for you to see what was said, and if you have any questions.

The lawyers in this room, and I have many instances of thinking, oh, I didn't say that, or I didn't ask -- and we look back on the transcript, and we did. So this is just something that we're used to and hope will be of benefit.

One other thing, preliminary, and I'm going to start this, and I'm going to end up with it. We need money. We got caught in this little problem here of no money, so we are trying to put forth some grants. I have no money for coffee for any of you, for donuts. I have been asked this morning, with regard to some of the people from DEA that are going to come over from Washington -- they're wondering if they could be reimbursed per mile for their travel expenses. We have no money there. We have, are advancing money so that the, what the -- with the expectation of getting it reimbursed for the Court Reporter. We don't need a lot. The Committee immediately before us somehow got five -- $50,000. I don't know how that happened, 'cause we got none; okay? So if anybody knows anybody that has $500 here or 1,000 there, or something -- I mean, seriously, that's what we're going to use it for, is little bit of coffee, donuts, and reimbursement of mileage for travel expenses, things of that sort.

Georgette, Mike and I are doing all of the paperwork and things, but we need that badly. We are very limited. For instance, we're looking at some drug companies, but we can't have any drug company that makes any CDS, for obvious reasons, so we're, we're going to try to do a little something for Astra Zeneca,

and people like that. And we are not asking for much -- you know, you give us $1,000, or something -- but we need, we're going to need about 10 to $12,000 by the time we get through here and, hopefully, we'll be able to come up with it.

But I know you understand Secretary Comer's position. To avoid the indicia of impropriety we have to be very, very careful of who we take the money from.

Scott Shellenberger is the State's Attorney for Baltimore County. He is the first witness out of the box. I say witness. I'm only joshing. He's the first presenter. We decided to hear from the Prosecutors first. LaRai Forrest is greatly cooperated, and Linda Bethman, to present people.

Scott, can you come on up here and sit down and you're, you say what you want to say. And I'll be very, very disappointed if there aren't any questions from Scott and the rest of the people. Everyone remembers how vociferous, and righfully so, the pain people were the last meeting with concerns. So Scott knows that, and they all know it and they, they want to answer your questions. And here are your concerns.

Scott has been the State's Attorney for Baltimore County for a couple of years now. He was a Prosecutor there for many years when I saw him as a

very, very young man. He's now a medium-aged man.

MR. SHELLENBERGER: Thank you. Good way to start the way -- medium age.

JUDGE FADER: He is a fine, excellent lawyer with good common sense who understands what's going on here, and who now will try to tell us why you need what you need and what you need. And we appreciate you coming.

MR. SHELLENBERGER: Thank you, Judge Fader. And I do appreciate you asking us here today and giving us an opportunity to present. And I would like to recognize you as a medium-age man.

JUDGE FADER: I'm not. I'll be 68 next month.

MR. SHELLENBERGER: How I practice, obviously, in front of you now, if I do the math, who was a, a younger man. So my name is Scott Shellenberger, and I'm the State's Attorney in Baltimore County. I'm not here alone today, because certainly I do not consider myself to be an expert on this issue. So while I'll give my overview of, of some of the things that we want to look at from a law enforcement protect -- perspective, there are other folks here who can probably answer more detailed questions.

I brought with me John Reilly, who is my Assistant State's Attorney who is in my Narcotics Unit

and who handles a great deal of coordination of our prescription drug cases. So, when the team management people want to ask questions, you're going to ask Mr. Reilly questions, because I won't know. Just kidding.

More importantly, in addition to John, also with us today are Roann Nichols. She'll go later on.

JUDGE FADER: Roann, where are you?

MR. SHELLENBERGER: In the back.

JUDGE FADER: Okay.

UNIDENTIFIED WOMAN: (Indicating.)

MR. SHELLENBERGER: Roann is an Assistant United States Attorney, and she's the Supervisor of the U.S. Attorney's Office drug enforcement cases.

Also with us is Agent Terry Riley. Agent Riley, he's --

UNIDENTIFIED MAN: (Indicating.)

MR. SHELLENBERGER: -- he's Supervising Agent of the DEA, the Drug Enforcement Agency.

And just, just as importantly, if not more, Mary Rochee is here today. She's the Diversion Program Manager at the Drug Enforcement Agency. She works out of the Washington Division, but it oversees Washington and Baltimore, large area.

It might be helpful if you hear from all of us before we start the questions, because I think each of

us has a little piece of the puzzle that, that we can kind of give the overview, and then, then you all can focus in on the person who can answer the questions most accurately.

Federal data has shown that nearly seven million Americans abused prescription drugs in, in the year 2007. That number represents more than cocaine, heroin, hallucinogens, inhalants and marijuana combined. That number of seven million is estimated to be nearly 80 percent higher than it was seven years ago, in the year 2000.

Recently it was learned through statistics that in the age group of individuals between the ages of 45 and 54, overdose deaths caused by prescription drug use now surpasses motor vehicle deaths as the number one cause of accidental injury. So to say that prescription drug abuse is a serious problem would be a tremendous understatement. Obviously all of you know, by virtue of being here and by your backgrounds, that this is a huge public health problem. And, as always, public health problems, particularly when they involve drugs, become law enforcement problems. And that's why we are here today, is to give you a perspective from the law enforcement agencies.

As all of you should be aware, 38 states --

that's 38 states, have some form of a prescription drug monitoring program. The last time I checked, their, their health care system had not come crashing down as a result of the systems that they have put in place. So, you know, we are just one of 12 who doesn't have something. And certainly there are places that we can go and look at, to our brother and sister states, for models. Like Kentucky, who is existed since '99, like Virginia who has a system.

The first thing I want to tell you that we, in law enforcement, want to do is tell you what we don't want to do. Okay. Law enforcement doesn't want to interfere with the adequate pain management of, of patients. That is not our intention. We also don't want to place a chilling effect on providers of pain management. We don't want to interfere with the doctor/patient relationship; we don't want to place undue financial burdens on either physicians or on pharmacies or those who dispense drugs.

Those are all things that we just don't want to do. Frankly, we all have enough business to keep us all very, very busy without going on all kinds of witch hunts. But what we do want to tell you is that the creation of a monitoring program can assist law enforcement in the jobs that we already have. It can

assist us in making it easier.

The other thing that it does is that these programs really protect the physicians and the pharmacists, as much as anyone else, because you are -- doctors, and physicians and pharmacists, are the first line of defense. You know, if you have access to a monitoring program, and if you're in an ER at 2 o'clock in the morning, you might be able to find out if the person that you're seeing that one time on that one occasion really does have a pain issue, or whether they're trying to scam the third doctor for the fourth day in a row. That's the kind of role that these programs can play.

On a personal note, I told a couple of you before I started I understand the problems that this cause. My dad was a pharmacist. He owned his own store, a mom and pop place, for many years, and then he worked for a national chain. The first job I ever had was at the age of 13 driving prescriptions to people's houses in Hamilton, Baltimore, on my bike. I listened to my father for 35 years complain about having to fill out all of the paperwork, all the third party and how, you know, all of this bureaucracies was now putting too much of a burden on him and not letting him become the pharmacist that he was. So I understand that creating

another level of bureaucracies can be a problem. We don't want to create an undue burden on, on anyone, but we do believe that there can be a balance. A balance can be struck between legitimate medical interests and concerns, and certain needs and desires of a law enforcement community.

Just to highlight -- and, again, it'll probably be best to hear from everyone before we go into questions, but here are a few things that we in law enforcement believe are a minimum requirement of what we would like to see in a system.

Number One. We'd like to see it, a statewide, single database-based system. It's certainly the, the easiest way to deal with this. We believe that, that the system should be searchable by physicians and pharmacists because, as I said, they are the first line of defense. Not defense for us or evidence-gathering for law enforcement, but for defense for you all to make sure that prescription drugs are not being diverted.

The database, we believe, should include Schedules II, III and IV. Increasingly, Mr. Reilly has told, me anecdotally, and what we've seen in statistics increases in numbers of Schedule IV drugs being taken by juveniles from their parents, their peers, and, and

other people that they have access to. We think this is very important.

Concerning the database and its searchability, and with reference to law enforcement, we do not believe law enforcement needs immediate access to the database.

We believe that two things can happen together:

Number one. The database and the professionals who run it can look at the database to spot trends and problems that they would then alert law enforcement about. This way, you would have professionals who want to secure the database and are concerned about confidentiality and patient management to only make referrals to Police agencies when they see trends and anomalies that need to come to law enforcement's attention.

Two. We believe that law enforcement should have access to this database information when following up on an existing investigation, and at that point there can be levels of access. And we deal with these levels all, all the time. Whether there's cause to go into a database based on your investigation, whether there's reasonable suspicion, whether there's probable cause, There are many levels that we, in the lawyer --

law community and the Police community deal with and understand what kind of level of information and -- 'cause you would need to have access to the database. But we think those two things can work together and, that is, the database giving instruments -- information to law enforcement, when necessary, law enforcement getting access to the database when there is cause.

We believe that the database should include some of the following:

One. The name of the patient, or some patient identifier.

Two, some type of numeric identifier of the patient that, date of birth or, perhaps, something more innocuous like a driver's license number, which all of us have and which all of us can get access to through the public records of the Motor Vehicle Administration.

Three --

JUDGE FADER: Just a second. Yes, you can, 'cause you --

DR. MARCIA WOLF: The little old ladies that don't drive.

JUDGE FADER: -- they'll give it to you free. They'll let you drive, but we'll take care of that, Marcia.

DR. MARCIA WOLF: Okay,

MR. SHELLENBERGER: You, you -- my sister doesn't drive. She has had a motor vehicle identification card --

DR. MARCIA WOLF: Okay.

MR. SHELLENBERGER: -- has, has an I.D.

JUDGE FADER: But that's a question that you need to ask again, okay, so we can take that care of that for you.

MR. SHELLENBERGER: We believe that it should have the, the drug that is being dispensed, the date issued, the quantity of the drug, the doctor and the pharmacy and, of course, the, the applicable DEA numbers that go with the doctor and the, and the pharmacy issue and/or the provider. We believe that those are certainly minimum requirements that can be beneficial to both the medical profession and to law enforcement.

We recognize that timing and when the database gets updated is certainly a critical issue, one that directly impacts cost. Obviously, for any database that exists in any system, the more often and more frequently it is updated, the better the data. The better the information, the more recent the information. We recognize that for certain people this may be very difficult to try and force them to update

the data every 24 hours, every 48 hours. Certainly within any statute there can be exception and waiver if there's a cost benefit analysis that has to be done, but our preference, obviously, is the more immediate the data, the better.

We believe that primary protections can be put into place so that all parties who have a stake in this matter can be properly protected, yet all of this goes not for us to collect evidence to prosecute people, but to go back to that original statistic that I talked about, and that is, to cut down on the seven million people who are addicted to these types of drugs, and to cut down on all those accidential deaths and overdoses, and get rid of this public health problem, or cut down on this public health problem that we have. I do not envision this database existing for us to go fishing and to find cases. We got plenty of cases. But I do think it could serve law enforcement needs once we have a case, or when the people who are running the database think there may be a case.

I appreciate your time. Mr. Reilly will answer all your questions. And, and I think, actually, after we all talk, I believe the, the next kind of best overview person to hear from would be Mary Rochee who is the Diversion Program Manager at DEA.

JUDGE FADER: And would you stay up here so that when the time comes to questioning, we can have them direct their questions to whoever will speak --

MR. SHELLENBERGER: Yes, sir.

JUDGE FADER: -- will want to? Okay. Thank you. Mary?

MS. ROCHEE: Yes.

JUDGE FADER: You know, there's another thing here, too. Let's just talk about money. What Scott has said with regard to money has been the subject of many grants in the past to help pharmacists-physicians defer the cost of all of this. The bad news is nobody has any money anymore. The good news is there's no way this program is really going to ever be implemented if the 2010 Legislature works on it until 2011 and then our President says we're all going to have money again. Okay. And I believe it.

All right. Mary --

MS. ROCHEE: Yes. Good morning.

JUDGE FADER: -- you come on up here, please.

MS. ROCHEE: Do you want to do questions now?

JUDGE FADER: No, no. We just have you make, you say whatever you want to say now, but come on, squeeze in here and sit down.

MR. SHELLENBERGER: She has her screen up.

MS. ROCHEE: You know, actually, Judge Fader, I'm going to stand, because I have my presentation. I'm sorry. Thank you, very much.

JUDGE FADER: Okay. Very well.

MS. ROCHEE: I would first like to thank LaRai Forrest for getting us on board. Terry Riley and I, with DEA, this is, the Prescription Drug Monitoring Program is something that DEA has been very familiar with for years. Obviously, with us being in the drug compliance business, I think it's very important for me right now to bring people in the room in, forward as far as how DEA functions and the prescription drug business.

UNIDENTIFIED VOICE: Can you speak up just a little bit?

JUDGE FADER: Can you, can you speak up a little bit?

MS. ROCHEE: Can you hear me now?

JUDGE FADER: But I'm a little old.

MS. ROCHEE: Simply to clarify our role with Diversion of pharmaceuticals drug abuse, et cetera, I think a lot of times we are misconceived and the, the public understanding what our role is with regard to the Diversion issue, drug abuse, is, is very important. And I think a lot of it comes from -- people perceive

DEA from strictly an enforcement form. When you hear DEA, you think of a special agent may be coming in to kick in doors. And we do. That is a major part of our mission, enforcing the drug laws in the country. And those are their defenses. However, on the Diversion side of the house, we have a very, I shouldn't say very different mission, but our mission is more of a regulatory nature.

Specifically, we focus our attention on the regulated -- communicating those registrants who legally handle control substances. So my comments today are going to focus very much on that. I'm going to go through a few topics very quickly. I know our time is limited here. I want to clearly define our mission for everyone here. I think because of the different people represented here it's important that you understand how we play with regard to DEA's mission in Diversion.

We have a twofold mission, Diversion side of the house. One of the primary parts of what we do is insuring a legitimate supply of controlled substances that's available for an analyst of chemicals to meet legimately chemical and scientific needs -- and that's a very critical area of our work -- in addition to us coming out for reasons, sometimes, that aren't so

favorable to our registrants. We do allot a liaison. And within the industry and the public, when people want to register chemical-controlled substances, our investigator's required to go out in certain instances and advise those registrants what's required, what the rules are, how they stay in compliance. So that is the major part of our work, to make sure that people who handle drugs are able to make them available and that they can stay in business because they are following the rules that are required under CSA.

We also have the other function, which involves preventing, protecting and investigation of, Diversion of controlled substances into enlisted channels. And they'll keep us very busy -- and is one of the major reasons why we are supporting prescription drug monitoring programs nationwide.

And to give you a closer look of some of the things that we get involved in, in addition to insuring access to controlled substances -- we don't ever want there to be an instance where someone needs to have their drugs and those drugs are not available to them. That's the general public and any other entity. How, and that goes along with identifying and deterring and preventing controlled substance abuse.

In Diversion we come out to do inspection of

certain facilities. Generally, there's, there's a schedule basis on which we do that for certain people that we register. The wholesale drug companies, we come out to do those. Basically, we're looking at their records to make sure they're handling controlled substances as the Federal law requires. And if they're not, generally we're going to give them the guidance that they need to make sure that all systems are in place to make that happen. We answer their questions. I'm -- it's on a daily basis I get questions on my desk from pharmacists, from physicians. I, I respond to a lot of correspondence to help our registrants stay in compliaince with the Federal law.

We also encourage and support drug addiction treatments. We register a very large number of narcotic treatment programs, as well as issue waivers for doctors who provide drug treatment in their offices under the DATA, Drug And Treatment, or Drug Abuse Treatment Act, and we advise these doctors narcotic treatment programs on the requirements that DEA has in place to make sure they can provide treatment that is in accordance with the Federal law as well.

We also inform the public and, and encourage public health initiatives by highlighting drug trends. And Scott talked a little bit about drug trends.

That's a very busy area for us, and our -- in the Washington Division and, and in our 21 field offices, Division offices nationwide we collect a lot of information. We want to know what, the overdoses that are taking place regarding certain drugs. We don't know what drugs are the hot movers, the drugs that are impacting the, the youth population, so we pay attention to a lot of studies; we collect a lot of data. And those, that information drives a lot of what DEA does in terms of scheduling, how we respond to what we consider sometimes epidemics taking place. I'm sure everybody in the room is aware of the Oxycodone craze that happened a while back, and it required us to focus very closely on the Oxycodone problem. So drug trends do, in large part, drive how we do what we do.

DEA spends a lot of time educating the community and public at large about prescription drug programs, because it is, we are a staunch advocate of them. And this is part of our reason we're here today, for -- to do just that.

And, last but not least, we work closely and cooperatively with our registrants, public, Federal, State law enforcement counterparts, just for the purpose of accomplishing our respective goals. And I will tell you that after meeting LaRai and Terry over

in the Baltimore office, I set out to follow up on what was going on in Maryland with the Prescription Drug Monitoring Program that we're trying to put in place here. I reached out to a lot of different people; I got some of their perspective. I didn't know there was so much, so many documents floating around, so I've had to educate myself over the last couple of weeks. But it has been good, and I'm glad that we are included as a part of this.

The chart that you're looking at now just lays out who is registered with the DEA. I wanted to show you that because I think it's pretty important to know who comprises our registrant population. As you can see, retail pharmacies and practitioners make up our largest, not including mid-level practitioners, make up our largest registrants' populations, and those are the populations who would likely be the focus of any prescription monitoring program that Maryland puts in place. I had asked question whether or not mid-level practitioners would be included, and that is because, in Maryland, a number of them have the authority to prescribe or dispense.

JUDGE FADER: You're talking about nurse practitioners, physicians assistants?

MS. ROCHEE: Exactly.

JUDGE FADER: Yes? The answer is yes?

MS. ROCHEE: Very well.

UNIDENTIFIED MAN: A quick question. In your practitioner (sic), did you include the Veterinary Committee?

MS. ROCHEE: Those are all the practitioners that we register. Yes, they're M.D.'s. Whether the veterinary physician -- would not be an M.D. If they're an M.D --

UNIDENTIFIED MAN: So that's not --

MS. ROCHEE: -- doctors are veterinary science; okay? They are M.D.'s, aren't they?

UNIDENTIFIED MAN: No.

SECOND UNIDENTIFIED MAN: No.

MS. ROCHEE: You don't have any veterinarians that are M.D.'s?

JUDGE FADER: Yes, we do, but for --

UNIDENTIFIED MAN: They are.

JUDGE FADER: -- but the overwhelming majority of them are a doctor of veterinary medicine.

MS. ROCHEE: Okay. They would be the, the doctors who have the M.D.'s would be considered the practitioners.

JUDGE FADER: Okay.

MS. ROCHEE: Okay. The others are mid-level

practitioners. I'm sorry.

UNIDENTIFIED MAN: Are, are they actually included --

MS. ROCHEE: Yes.

UNIDENTIFIED MAN: -- with the veterinary physician?

MS. ROCHEE: Yes.

UNIDENTIFIED MAN: Doctor be included in the mid-level?

MS. ROCHEE: The M.D., I think the veterinary doctor would be at -- mid-level practitioner in Maryland.

UNIDENTIFIED MAN: Okay. I just wanted to make sure it includes other man -- they're called M.D. or DVM, depending which college they graduated from.

UNIDENTIFIED WOMAN: Could be DVM.

MS. ROCHEE: Yes. That brings up the question about the dentists as well. The dentist who is an M.D.

UNIDENTIFIED WOMAN: No.

DR. WOLF: No. To get an M.D. degree, for the most part --

UNIDENTIFIED MAN: The dentist, the dentist, the chiropractor, chiropractor, I want to be clear.

MS. ROCHEE: Would be under the mid-level practitioner, okay. They don't have an M.D. degree;

they don't get a practitioner registration in DEA.

JUDGE FADER: Well, you have made an observation that I've noted, and we will follow up on, to answer Ramsay's question in great detail.

MS. ROCHEE: Okay. But as you -- okay -- thank you -- as you can see, we have about 1.3 million registrants, total, that we register that we have responsibilities for regulating as well.

Okay. Here are the numbers for Maryland. I just want to lay out who is represented amongst our registrants' population in the State of Maryland. And there's a total, about almost 26,000 total registrants with practitioners in probably the largest, comprising the largest. Just so that you know where we are in DEA, I have oversight for DEA's Washington Division, which includes Maryland, Virginia, Washington and West Virginia. And we have about, I want to say, approximately 35 staff persons who, whose direct focus is to address the Diversion issues in those areas of responsibility.

I listed the players in a prescription drug monitoring program, because I think that in order for it to work, all of those entities are going to be very critical players. And I don't think it's going to focus on any one entity that's listed there. Law

enforcement certainly can't do its job with regard to a subscription monitoring program without the physicians and pharmacies cooperating, and the public at large, as well as the regulators. And I think it's just -- sometimes I've heard physicians maybe reference that maybe this is a law enforcement thing, and it clearly is not. It's something that, I think it's a win-win situation that we all benefit from.

Just briefly, I want to talk a little bit about how prescription drug monitoring programs have impacted the DEA's Diversion mission. I will tell you when I came on the job, about 25 years ago, looking at prescription information required a lot of footwork. We went out physically, we walked into pharmacies individually and looked through their paper prescriptional records, and the two states in our area that now have operational programs, it has certainly reduced the volume and the time, man hours, that have to be expended to look at information. It's also a major dollar saver in terms of amount of funds it takes to manually review information. The data generally is much more current, doesn't take as long to review.

There is a very positive impact on the volume of control substance abuse with regards to physicians and pharmacies, and I think it's, it's a very good tool

for a pharmacy, for the health community, as far as getting to provide, to better treat their patients who may have potential abuse issues; okay? I don't think a lot of times it may be so clear when patients come into a doctor's office that, potentially, they do have an abuse problem. However, if doctors are able to access this information, they can see their patient maybe going to four or five doctors and getting the same drug. That's something that they need to be looking at and they need to be aware of. And you don't have the problem or the opportunity that a doctor will be duped as happened, what happens in a lot of instances.

I think we also have to look at the fact that these programs encourage closer relations between the State agencies and DEA. We are constantly reaching out to those agencies in our area that have prescription monitoring programs. We share investigative information with them. They consult with us on a regular basis, and it has done a lot to improve our working relationships. And I can't stress enough how, how important that is, because we cannot do our jobs by ourselves. The State wants to do their job without law enforcement, without the physicians that they register and pharmacists, et cetera.

And here are just some quick facts regarding

prescription drug monitoring programs. Contrary to popular belief this, we cannot walk in, DEA and other law enforcement agencies, and just grasp this information off the cuff. We have to go on, with some solid basis. Generally, that there be an active investigation. That there is, there's a, some evidence that a certain drug is being abused a lot. There's some high level overdoses taking place. We need to focus on the trends' information. We have to have a reason to get this information. We cannot walk into the Board of Pharmacy, whoever the keeper of this information is, and just take it or have access to it. I know that's a major, major concern.

In addition, I -- yes?

MR. CLARK: Do you think that under -- still do that under administrative subpoenaes, or do you need a --

MS. ROCHEE: Well, in the case of an existing Prescription Drug Monitoring Program --

MR. CLARK: (Nodding head yes.)

MS. ROCHEE: -- there's criteria established as to how you go about getting that information, and it's very much adhered to.

MR. CLARK: I'm retired DEA. We used to use administrative subpoenaes a lot.

MS. ROCHEE: Mm-hmm.

JUDGE FADER: And sometimes there's built into the law with the State's Attorney for Baltimore County that I had to sign orders to allow the State's Attorney to have various financial and other information to disclose that information. So, certainly, that is a prospect, also, to be considered.

MS. ROCHEE: I think the level of access is pretty critical, because you're looking at -- you have your State Police, you've got Police Officers, sometimes the State investigators for regulatory agencies, DEA. How the information should be distributed is going to be a very -- something to focus on very closely.

I think a lot of times prescription monitoring data is perceived as a targeting tool. And for DEA -- excuse me -- I didn't mean to stand in front of you -- for DEA, it certainly is not, we cannot use this information as evidence if we are going to court. We will glean certain information when we look at it, and I'll give you an example.

If we have a complaint in our office about a certain pharmacy, for instance, we may want to look and see if this pharmacy is on the top 10, just one of the top 10 dispenser in the state for a certain drug, if

there are patterns there that require us to focus in on them fairly. And that's how that information is used. Sometimes it's used to corroborate some other information that we have. But I don't think we can go to the list and pick some registrant off the list and say this is who we're going to target and, by itself.

Another area of concern has to do with confidentiality. I did some research just to see what has happened, historically, with confidentiality with regard to prescription drug monitoring data, and in all the programs that are in operation we didn't have any reports documented where confidentiality had been breached. I was glad to hear that, because I think any system like this is subject to being abused. But I could not find any evidence where that has happened.

I do want to just mention, again, and I keep putting stress on this, that the use of this data certainly has increased how efficiently we're able to do investigations. Time is of the essence when you're doing any kind of investigation, and it's very important that we not get caught up in trying to get information. I can tell you sometimes we have a grand jury subpoena. When people don't respond, it takes, it just takes the edge off of what you're doing. It cuts your continuity. And if you can go in and obtain

information timely, keep things moving, I think it certainly makes things happen much better. And all of this is to say that DEA very much supports the idea of prescription monitoring programs. I think that the oldest program that I've found out about, and Terry and I have been talking about, in California they've been in existence since the 1940's. And to look at how many states are actively running these programs now -- and I think from having talked to a number of people who are the keepers of these programs, and to hear the advantages on how it's making things happen better in their respective areas, I just don't understand why they haven't happened all over. But I think that you have enough interest here in the room. I can tell that people are very tuned in. And if this is something that -- very interested in making happen, I certainly want to let you know DEA will do whatever it can to assist with that effort.

And this was just a reiteration of some of the concerns regarding a Prescription Drug Monitoring Program. I know probably a, an area that is going to have to be looked at very closely is who will be the keeper of this program. And every state that I've looked at, every program is different -- either who keeps it, how, how it's run, how the information is

disseminated, what schedules it has, who it requires to report. You'll find a different combination if you look at each program, I can guarantee you.

But the cost is something -- and, Judge Fader, you were just discussing that, of obvious concern, especially in, in this fiscal time we're looking at across the board. I listed the two primary sources of financing or funding of these programs, and I strongly encourage the, rhe Council to start looking at those closely. And another reason why is because a number of states are putting together Methamphetamine-type programs, and they're, they're looking for funding. I know they're going to be sources for funding, so it's going to be very critical that if Maryland is to go after this money, that you get on board right away.

JUDGE FADER: Thank you. And, Miss Zoltani is way ahead of you.

MS. ROCHEE: Okay.

JUDGE FADER: She's preparing everything right now.

MS. ROCHEE: Very good.

JUDGE FADER: Okay. Thank you.

MS. ROCHEE: And this is just DEA's website, if anyone needs to go on, I encourage you it's a wealth of information available. And that's the end of my

presentation.

JUDGE FADER: Okay. Scott, who's next?

MR. SHELLENBERGER: I think next would be Miss Roann Nichols. Miss Nichols.

MS. NICHOLS: Can I sneak in there, Scott?

MR. SHELLENBERGER: Yes.

MS. NICHOLS: Good morning.

THE GROUP: Good morning.

MS. NICHOLS: As Scott had said, I am Roann Nichols. I'm an Assistant United State's Attorney for the District of Maryland. If you don't mind, I'm going to sit down. I am the Deputy Chief of the Civil Division. I'm responsible for supervising cases involving civil Diversion investigations and prosecutions, and I'm also responsible for supervising civil health care fraud investigations in our office. So I bring to this not only experience in civil Diversion, but also in health care fraud.

And I think there are some, a couple of parallels that are important that I'd like to talk about, but before we talk about that I just wanted you all to know that I'm not going to talk about age at all. These guys can talk, but it's not going to be me. So we're going to stay away from that subject.

Okay. Okay. I think Judge Fader circulated

some press releases from cases that my office has recently handled, and we brought those in today because I think they are good examples of the kind of cases that we're seeing and the kind of cases that we prosecute. You have a press release there for New Care Pharmacy. During a 22-month period of time, New Care dispensed 9.9 million dosage units of Hydrocortisone. The national average is 160,000 units. So you know that's it's a, it's not even close to the line.

The scripts had been issued by doctors in Florida for patients around the United States, and the pharmacy and its owners obtained $20 million in gross proceeds. We also entered into a civil settlement with McKesson, because the McKesson facility located in Landover, Maryland sold three million units of Hydrocortisone to New Care, but had failed to report to the DEA any suspicious orders. So the, the settlement for $13.5 million -- there were other allegations involving six other states -- five other states -- excuse me -- and Makessan even paid three -- $13.5 million to settle the allegations of failing to report suspicious orders in all six states.

JUDGE FADER: Does everyone know that Makessan is a distributor? In other words, the middle person between the manufacturer and the pharmacy, or the

physician. And there is, I think, what, Cardinal's the biggest --

MS. NICHOLS: Yes.

JUDGE FADER: -- in the country? There's a, I think three or four of them --

MS. NICHOLS: Yes.

JUDGE FADER: -- have 80 percent of the business, or something.

MS. NICHOLS: Right.

JUDGE FADER: There's a number of distributors. Makessan is one of of the biggest distributors.

MS. NICHOLS: And, of course, you all know that under the Controlled Substances Act, there are recordkeeping and reporting obligations that pharmacies have and that distributors have.

But, again, this is a, you know, this is another example of a case that really is not -- you know, it, it's not, we're really not splitting hairs here. These are, these are big cases, big disparities and big numbers.

The -- we also prosecuted a case involving defendants who operate, who operated Internet websites. And in less than two years they filled two million doses of Phentermine and, also, these were the Phen-Fen

drugs. They sold $8 million of Phen-Fen. The customers completed online questionairres which were authorized, to use the term loosely, by physicians and filled by these pharmacies owned by the defendants, these brick and mortar pharmacies.

And, finally, the, the last press release there involves a, a woman named Kathleen Harris, who obtained prescriptions of Methadone, Oxycodone and Hydrocortisone from unwitting doctors who didn't know that she was obtaining these drugs from multiple doctors and multiple pharmacies, and selling those drugs to others, including high school students in Western Maryland, one of whom died of an overdose. And Harrison, Harris and her codefendant were sentenced to 13 years and 20 years, respectively. And I think we can all understand that.

I think in the, the Harris case is a good example of how -- and I, I'm going to be repeating some things that Scott said and that Mary said, and sort of reiterating them. But I think the Harris case is a really good example of how a PDP can assist physicians and pharmacies who are really on the, the front line of public health. And, and rightfully so. I, I think these physicians were, were aghast that they had been made by this woman to obtain prescriptions and to sell

them to high school students.

And physicians ought to be able to access that information. You, you all out there who are physicians and who are pharmacists know that. You know, you have a sense when somebody comes in to get a prescription to, either to obtain a prescription or to have a prescription filled -- I, I mean you've got a sixth sense about these things. You, you know -- can, can have some questions about whether that's a legitimate -- this is a legitimate need for pain medication, which is important and a significant medical concern, and, and, or whether you are, you know, as these doctors were, being played.

And if you have access to a PDP, you are going to be able to search that person; you can search that database by patient and, and see, Well, where's that patient been, how many other doctors she obtained scripts from in the last month or two months and, you know, you can take it from there, counsel the patient, refer the patient for drug treatment, you know, whatever your options are.

So I think these cases, these, these press releases demonstrate that. And, and again I'm going to be repeating some of the things that, that Scott has raised. That law enforcement is not interested in

getting involved in the day-to-day operation of the practice of medicine. We're not doctors. We're not going to tell you how to prescribe, or how many to prescribe or who to prescribe for. I mean, that's, that is a medical determination made by a physician.

But these cases, and, and these cases are such that we -- you know, we're not going to be going after a, physicians or pharmacies where, maybe, the, you know their, their prescription rate is 180,000 units as opposed to the national average of 160,000 units. These are far and away really not even close to the line.

A couple of other things. The, with respect to confidentiality -- and I know that is a huge concern for this group as it is a huge concern for law enforcement because, as you all may know, under HIPAA privacy provisions, there are penalties for violating HIPAA, there are Federal penalties. So we can prosecute entities who violate patient confidentiality and who violate HIPAA. So we take it very seriously in law enforcement, the agencies, the agents take it very seriously and the, the prosecutors take it very seriously, as well.

We maintain information that we obtain in our health care fraud investigations securely, and we limit

access to individuals who have a need to know for purposes of invest, of investigating a health oversight or a law enforcement investigation. And --

JUDGE FADER: Now, the statute spells out all of that as to who you can make information available to?

MS. NICHOLS: Correct.

JUDGE FADER: Okay.

MS. NICHOLS: Now, I would certainly believe that the type of investigations that we're talking about here, Diversion investigations, affect health oversight, or qualify as health oversight under HIPAA. And in that case we can request information without a subpoena. We have to represent -- when, when we, in a health care fraud investigation, when we go out and attempt to secure information from a hospital or from a, a pharmacist or from a physician, we represent that this is a health oversight investigation, and under HIPAA we're entitled to receive the information. I think that's, that's certainly an appropriate avenue for you all to consider in these types of cases, whether you -- in, in addition to considering whether you need a, we would need an administrative subpoena or a finding of reasonable suspicion or the like. So that's another factor.

Another point is that what, what -- one of the factors that we all are really looking at is time. And I'm sure you all can understand this and relate to it. There's never enough time in the day. There's never enough hours in the day. And in one of the reports or one of the materials that you all handed out, the State of Kentucky reports that with the PDP their Diversion investigations have been reduced from a, an average of 156 days to 16 days. And that's, that's incredibly significant for a couple of reasons.

First, if we can reduce the time to investigate these allegations, we're not going to have a New Care Pharmacy that is able to, you know, that is able to sell almost 10 million doses over 22 months. We're going to have that information like this. I mean, we're going to, we're going to know what they're up to. As soon as we have an open investigation, we can go to the State, we can say, what are the sales. We're not going to have DEA agents pouring over paper records and paper files. I mean, you, you know, what's that, what that's like.

MR. CLARK: (Nodding head yes.)

MS. NICHOLS: And we will have immediate or nearly immediate -- and by that I mean we have to go through someone, but we'd have to practically at the

push of a button get information about this pharmacy, because you're going to have information -- and this is to pick up a point that Mary raised -- we're going to have information for everybody who's got a DEA name. If you can prescribe CDS, then -- and you have a DEA number, then you need to be on the database. That's everybody -- whether you're veterinarians, or certain -- nurse practitioners, or M.D.'s, whatever, dentists.

Because the other things that we know in law enforcement is that if there is daylight, the, the diverters will run for it. I mean, they're like, you know, they're like a running back. They will run for daylight. So, if, if we are only keeping data for M.D.'s, or the, they're dentists, or they'll go to, you know, they'll find a certified nurse practitioner, or they'll find a P.A. -- so that the data has to be complete. You got a DEA number, you're in the database.

MR. CLARK: We had a veterinarian who obtained more cocaine one year than Johns-Hopkins Hospital and University Research combined.

MS. NICHOLS: Great example. And with a database, whether you, whether this is operated by employees for the State of Maryland or by contractors, these, these investigators, these contractors, the

people who are operating the database and maintaining the database are going to look and see that. They're going to be looking for trends. They're going to see that and say, whoa, this can't be right. And we'll, you know, we'll be off to the races and we'll stop it, which is what, the purpose of these efforts are all about.

We see this in health care fraud investigations where Medicare, Medicaid and private health insurers all have benefit integrity units where they, where they are observing and they are doing data-mining, and they're looking for, you know, a doctor that is so far into the stratosphere that, you know, questions are raised and, and we can start looking at them. So that's, timing is one thing.

Also, as a taxpayer, I am pleased that my tax dollars are being used effectively. So if the DEA can investigate a case in 16 days as opposed to 156 days, that's saving U.S. tax dollars, which is certainly important in these tough times, but is important every day, every year, all the time.

Obviously, the public health concerns have been addressed by everyone here. And I don't need to comment on that.

Also the, this time lapse between

investigations. We get cases and look at cases sometimes that don't pan out, but we still have to investigate them. We get complaints; people have concerns, issues are raised. Someone goes out and gathers records. Pharmacies have to respond to those requests to, for records, DEA Diversion agents have to go out and review the records and it takes a lot of time. And at the end of the day -- it may be three, six, 12 months later -- we find out there's nothing there, so we decline the case. But everybody has spent time and energy and money looking at a case where there's nothing there.

So we'll also have the ability in a, in a shorter turnaround to say we don't really, there's really nothing here. You may have a complaint; a, a patient or a customer may have a complaint about one thing or another; pharmacist may have made a mistake or there, there just may be a, a -- you know, it may be an irascible patient. Not that that ever happens, except for my dad. But, you know, those kinds of things can be turned around.

DR. WOLF: I think there's a flip side of this, though. When you have more time, you have a bit more perspective, and you have some time to get a handle on whether or not it was a mistake. Because

you're looking not just at an instantaneous slice in time, but you have the time to obtain more impressions and more of a perspective on it. How valuable is that?

MS. NICHOLS: I think it's hugely valuable. But I think when, when we've been, when you have been in this business for a while and doing this for a while, we kind of have that sixth sense, too, just like doctors do, just like pharmacists do, just like medical providers do. And, anyway, you have a sixth sense of, you sort of know it when you see it. And the fact that it, that we can get the data and look at what's been happening for a period of time, you know, is, is going to inform our sense. It's just going to the, cut down on the amount of time it takes us to gather objective data, to then apply that experience and to apply that understanding about what's going on. That doesn't mean that we won't go out and ask questions, but it means that we're going to be able to look at the data and say, okay, well, maybe there was this circumstance, maybe there was this complaint. But when we look at the pattern of the last year, or the last two years, you know, this is a, you know, this is an aberration.

We may say that, as well. Let's say a pharmacy has a spike in prescriptions for a month or so. If we can look at the data that goes back a year,

or possibly two years -- and that'll be an issue for you all to consider when you decide how long you're going to maintain data, I, I would urge you, from our perspective, to keep it for a while, to -- ideally, for a couple of years, so that we can do that. If you've got a spike, if you've got an aberration, can we go back and look and see, well, you know, is this really a, you know, have kind of a blip on the screen, or is this a pattern? You know, do we see the, the data going like this, or do we see it going like this? And we can ask questions about that period of time. Now, that is just extraordinarily useful.

DR. LYLES: What database do you use now? You obviously, you know, are mining data from somewhere, the way you made your presentation. So what are you, what are your databases that you're using presently?

MS. NICHOLS: We don't have databases in Maryland.

DR. LYLES: For -- no, no, no. This is Federal.

MS. NICHOLS: Oh, Federally.

DR. LYLES: You're speaking Federally, right?

MS. NICHOLS: I'm speaking Federally, but we also use State databases, so we have access to -- we work with our partners at Medicaid, and what we can

obtain is for Medicaid patients, and for Medicare Part D patients. And then for private insurance patients we can obtain information about patients, and physicians and pharmacies, but that information is not combined. So we have to go to Medicare, and that is what's called a, a program safeguard -- well, it's now AMEDIC, but it would be a program safeguard. Those of you involved in this field know CMS is kind of in a constant state of transition about who maintains this data and who reports it. So we can go to Medicare Part D. Then we go to Medicaid and get that data. And this -- I mean, how many independent insurance private insurers are there in the, we can -- pardon?

DR. WOLF: There's only a limited number of PBM's.

JUDGE FADER: Yeah, for --

MS. NICHOLS: Okay.

JUDGE FADER: Yeah, for prescriptions, I think three of them have 90 percent of the business, or something.

DR. LYLES: Absolutely.

MS. NICHOLS: So we go to the PBM'S, but those databases don't necessarily talk to each other. And if -- and what we're talking about here are controlled substances. And if all of that information -- I mean,

that's where you really cut on. You, you can, you can improve your efficiency, because you've got one database.

DR. LYLES: But you have access to SureScripts, things like this.

MS. NICHOLS: I have never accessed those. Mary, can you speak to that?

DR. LYLES: This is an industry database that everybody uses in -- pharmacy, and physicians and so forth.

JUDGE FADER: Mary, do you know the answer to that question?

MS. NICHOLS: I've never used those databases. And, you know, private databases, we don't have direct access to that. We, we can't -- no, I've never used that database.

MS. ROCHEE: With regard to SureScripts, DEA would not use that information because it's not DEA information.

DR. LYLES: Mm-hmm.

MS. ROCHEE: And we don't have agreement with SureScripts to say it's this or it's that. The only database that we would be using would be about controlled substances that I could say pulls everything in, because there are closed data. I don't know how

many people are familiar with its automated reports and consolidated order system. Basically, it tells us what our pharmacies, our distributors are purchasing in terms of narcotic drugs, okay, only.

DR. LYLES: Mm-hmm.

MS. ROCHEE: So we can tell if a certain physician, or which physicians in the State of Maryland are purchasing, say, Oxycodone, 'kay, and it identifies them by their DEA numbers. That's our tracking system for who is purchasing controlled substances. But we do not have a prescription database, per se, that gives us that information.

DR. LYLES: But you could access industry databases.

MS. ROCHEE: I guess if industry gives us access to it, yes. But I don't know that we would cite that information, because we have not --

DR. LYLES: Because all Blue Cross/Blue Shield, all United Health Care, all Cigna, all Aetna and so forth are on these databases. Everybody in this room who has health insurance is on that database.

MS. ROCHEE: It's because of SureScripts --

DR. LYLES: Yes.

MS. ROCHEE: -- database. Okay. We, we just have not utilized it.

JUDGE FADER: Mary, Dr. Robert Lyles is the one that is going to head our subcommittee who is talking to you now on these databases.

MS. ROCHEE: All right.

JUDGE FADER: He's very informed about this. And this is, one of our objectives is to put this all together to make it easier, more accessible, more confidential.

MS. ROCHEE: Okay. Have no problem.

JUDGE FADER: So that's who's talking to you about it.

DR. WOLF: Is it time for questions yet, or should we --

JUDGE FADER: We have couple of, one more person. Who is it?

DR. LYLES: Oh, I'm sorry.

MR. SHELLENBERGER: Yes, I do think Mr. Reilly can address a little bit about what you're requesting.

DR. LYLES: Surely.

MR. SHELLENBERGER: Again, we're sort of talking about these number, certain databases, and you're able to give these different names. The whole idea is to be able to consolidate them into one database for everyone to have access and to have a uniform way to access that through law enforcement --

whether that, whether it's through an administrative subpoena, whether it's through the, HIPAA to be able to have that for everyone to search off the same one, for everyone to be able to look at it, that's the goal.

So whether, whether a detective goes to a doctor and says, you know, we have seen an inordinate number of scripts with your DEA number; we don't think you're involved, but down in Lexington Market your DEA number is being passed out like candy. You know, you're going to go to a doctor saying your DEA number is being used. We notice your office manager's abusing them. They are related to a household number of someone we have picked up on an investigation. Those are the kind of things we want to be able to do. So you, yourself, would be able to go into those, one database, and check to see whether your DEA number's --

DR. WOLF: Yes. One of the perspectives from a treatment perspective is in being able to get accurate data when a patient is into my office to make a decision. There is not going to be a single database, because patients have mail order prescriptions that come from far away and other states. They can, some of the patients live across the stateline --

MR. KOZLOWSKI: Yeah. Mm-hmm.

DR. WOLF: -- or people that are close to D.C., so they're not necessarily filling prescriptions in the same state where we're collecting the data.

MR. KOZLOWSKI: Mm-mm.

DR. WOLF: Do we have the means in the legislation we come up with -- to mandate that where those prescriptions are being filled report to the Maryland system, and my understanding is probably not.

UNIDENTIFIED VOICE: No. We'd only be able to coordinate the Maryland system. But when, when DEA is able to look at the, you know --

JUDGE FADER: Now, just, and just a second.

UNIDENTIFIED VOICE: Yeah.

JUDGE FADER: The Maryland Board of Pharmacy has a right to make certain requirements for a nonresident pharmacy. The expert on that is Linda Bethman, who is the attorney for the Board of Pharmacy, so I'm not so sure --

UNIDENTIFIED WOMAN: Right.

JUDGE FADER: -- that you're going to be completely helpless in this regard, but Linda will have to address that.

DR. FARAH: I have a quite, I have a series of four major questions I would depose, would like to pose to you, because if out of 38 states that have done

this, surely there's some experience somewhere of how to address some of these issues. And, of course, we're not knowledgeable of that what's happening, but it's very critical. Because if we're spending the manpower, the time, the efforts to have solved one-tenth of the problem, you have to question whether this is the right venue of how to do things.

And, and I would like to bring this up because it consolidates all this. In Maryland, particularly. We're not dealing with just Pennsylvania.

DR. WOLF: No.

DR. FARAH: We're dealing with D.C., with West Virginia, with Maryland, with Delaware and they're all accessible within 20 minutes. So the issue is not a Maryland database; the issue is a regional database that we have to be focusing on, because otherwise it's, it's really very, very diluted. And that's number one.

Number two. The Internet, how are we going to grasp the, the whole concept of these prescriptions, medications coming to us? I, I can tell you maybe half of the Benzodiazepine overdoses are and, an overutilization, we see are Internet prescriptions of Benzodiazepine that come through the mail.

And number three. Who is accessing the database? Would we be dragging the individuals who are

literally going on the database and knowing what my patient is getting, what I am prescribing, et cetera? Because employment -- I mean, you can create a whole infrastructure industry of people getting into there where -- that, that are a vet, or a dentist or what have you to have a business of going into the database, looking who is prescribing and have a major employment impact. So are we going to be tracking who has access, somehow? Or they have access, are they accessing information to have patients they are not taking care of? Are, are -- these are very critical. Because if you don't think of it at the outset, cleaning up later is, is a disaster. Who is going to be licensed to get into in database, look at it. Are we going to be monitoring these internal affair kind of a situation?

Thirdly, the, the, the process of when is, actually, you're to go to an office and say, hey, Doctor, your DEA number is floating around down in Baltimore, and you're up in Hagerstown. What, what, what's up with that? When -- who is going to look at the data to recognize that, potentially, this is an issue? I mean, it's so flagrant when you have, you know, a million heads or 100,000 heads. But I can submit to you that a lot of the physicians that we are seeing and we are disciplining are not people that have

millions, are people who have tracks of poor medicine and they're not doing it right and we're disciplining them.

But, but we go through a very thorough evaluation, a lot of investigation, a lot of people looking, is this proper medical care or is this not proper medical care. So long before it ever hits a Police Officer's investigative unit somebody should be looking at this data and look at the correlations. I want to know how sophisticated is the process of looking at this to see if it legitimately is raising up a flag that's worth looking into.

And, so, I don't know, the integrity of the processes, of, of how you are getting the data that, hey, we may potentially have a problem in here. Because if you are a pain specialist, okay, you going to have more prescriptions. If, if you are an oncologist, you may have more of this and more of that. But today when we are giving licensures for physicians to go do Buprenorphine, some people are going to be dabbling in some areas of addiction and -- I think who are not there before. But how confident we are that they're competent, what they're doing, et cetera?

So who is looking at, at this information before it becomes an issue, which is going to come up

mobilize -- so much practice abuse and, and investigation -- so that we can get the proper answer? I am 100 percent confident that we need to have something in, as far as prescription drug monitoring. We absolutely need that, because I see it today. Five years ago most of my patients were heroin addicts. Today most of my person -- my patients are patients who have been addicted to medication. There's no question that it's something to be done. But it takes a lot of time and effort, and we need to have the know-how of when are we going to trigger that part of investigation.

JUDGE FADER: Now, for the presenters, the gentleman that is talking to you is Dr. Ramsay Farah, who is the Secretary of the Maryland Board of Physicians. So for those of you who want to communicate with him -- and he will communicate with you -- I think you should know the etiology of where he's coming from with great experience in this regard.

MR. SHELLENBERGER: And if we, we could maybe just hear from our one last person, and then try, each one of us, address some of these issues. And that, that would -- sorry to save you for last back there -- and, and that's our representative from the, the DEA, Agent Terry Riley. Mr. Riley?

MR. RILEY: I think Mary covered, pretty much, for the DEA.

MR. SHELLENBERGER: Okay. Well, then, you are the smartest person here by, by taking that position. So, so now somebody's got to answer all Dr. Ramsay's questions. So I was hoping you were going to do that.

MS. NICHOLS: Yeah. Can I just, I'm not going to answer all of them, and -- but I do have some thoughts. First of all, there are 38 states out there who have PDP's, so there is a lot of experience. There are a lot of, I would think, maybe some wrong turns that were made that were subsequently righted, and a lot of folks out there who have experience with just the kind of things that you're talking about.

And I guess one of the -- the good news about being one of the later states to develop this PDP is that you know there's a, there's a wealth of information out there.

MS. ZOLTANI: Excuse me.

MS. NICHOLS: Yes.

MS. ZOLTANI: Sorry, sorry to interrupt. I just wanted to mention to you that right now we're putting a plan together trying to get some money, a planning grant to set up a prescription drug monitoring program. And the plan is to visit some of these

states --

MS. NICHOLS: Mm-hmm.

MS. ZOLTANI: -- like --

MS. NICHOLS: Kentucky, and what have you, mm-hmm.

MS. ZOLTANI: And, matter fact, if you would like to be one of the people going, that be great, 'cause we're going to be talking to see who wants to go and who would be going.

DR. FARAH: And, and just for the record, when you're looking at funding, I would very much put to legislative efforts so that some of this money seized with all of these fraudulent things that's happening would be designated for the purpose of what we are doing here. I think this is the easiest and biggest source of income that we can get, is putting legislation that we get to keep some of this money so we can run with it what we're doing here. That's as free money as you can get for, for -- and just so everyone knows, I'm trying to set up for the --

JUDGE FADER: It's LaRai Forrest.

MS. FORREST: LaRai Forrest. Our next meeting, somebody from -- it's Agent Finley (phonetically) and Ralph Orr, who is part of the, Ralph Orr oversees the, he's on the Board of Pharmacy in

Virginia and he overseas the program. Him and Special Agent Finley are going to hopefully come next time, provided that they can get the funds to come and present with us how Special Agent Finley actually accesses the, the prescription program that they have there in Virginia and then explain how that program works.

So it will be very beneficial to how an active program works now, and maybe we'll, perhaps, answer some of these questions that you're asking now.

JUDGE FADER: Now, LaRai, when they seek, they're asking -- and you just told me today -- seeking, like for reimbursement for miles, or something of that sort, whatever?

MS. FORREST: (Nodding head yes.)

JUDGE FADER: Okay.

MS. FORREST: Yes. And --

JUDGE FADER: All right.

MS. FORREST: And I'm not exactly -- I told you we had no money, so --

JUDGE FADER: Would you ask, would you ask them?

MS. FORREST: So he's going to work that out, I think, for themselves.

JUDGE FADER: Would you ask what they want --

MS. FORREST: Sure.

JUDGE FADER: -- and get an idea of the mileage? Because, as I said, we're trying to work on some of this for just reimbursement of mileage, for some coffee, donuts, things of this sort -- and the Court Reporter. Most of the legwork will be handled by Georgette, and Michael, and myself and some help I'm going to get from Maryland's Law School. But we do need some money. Have I said that enough? Okay. With regard -- you know, with 500 here, a thousand something from one of these companies.

Let me ask a question. Who can get us the latest statistics on Emergency Room admissions? My understanding was that it was 25 percent of all of the people admitted to Emergency Rooms were because of some drug problems, nonadherence, things of that sort. Can you get us a breakdown into any of that?

MR. KOZLOWSKI: I will, I will give you electronic access to the later reports issued by the Commission.

JUDGE FADER: Okay. That'll be fine. But how many of those are CDS-related as opposed to noncompliance? Would you tell your name?

MR. KOZLOWSKI: Bruce Kozlowski, Director with the Maryland Health Care Division.

JUDGE FADER: Okay. All right. And that could all be very, very important, too.

MR. KOZLOWSKI: Be more than happy to do that. If, if you all could tell me what agency in Virginia is handling the particular database it would be helpful, because I happen to be in Virginia, or Virginia resident.

MS. FORREST: I believe Pharmacy.

UNIDENTIFIED VOICE: I believe it's Board of Pharmacy.

UNIDENTIFIED WOMAN: Virginia State Board of Pharmacy.

MR. KOSLOWSKI: If you should run into difficulty, and maybe we can assist you.

MS. FORREST: They seem to be working out how they're going to come up here and --

JUDGE FADER: Okay.

MS. FORREST: -- and finding relatives to stay with and whatnot.

JUDGE FADER: Some of these people, like Kaiser Permanente, people like that, Aetna, this all has the ability to save them a lot of money with regard to hospitalizations and things, too, so they should be interested in this.

MS. ZOLTANI: Talk about Ralph Orr, I'd be

working with Ralph Orr. And I heard -- I met him, and and I know him pretty well. So what I can do is I can give you the, whatever information you need so if you wanted to get ahold of him, or what have you.

MR. KOZLOWSKI: Okay.

MS. NICHOLS: I know that there are some states out there -- this responds to a, another question -- I know that there are some states out there that have some type of a cooperative coordinating agreement --

MS. ZOLTANI: Yes.

MS. NICHOLS: -- so, perhaps, that is something that we can work out with Pennsylvania and Virginia.

But, you know, going back to the running for daylight analogy, you know, if Maryland doesn't have a PDP, then we're daylight --

MS. ZOLTANI: Yes.

MS. NICHOLS: -- so --

DR. WOLF: One of the numbers that keeps cropping up is that 38 states have enacted legislation, but not all of the states have actually implemented the program yet.

MS. NICHOLS: Right. They're in the process, some of them are in the process.

DR. WOLF: And some of the ones that have implemented have not even been collecting data for two years. So does anybody have a number of how many of these systems are actually mature?

JUDGE FADER: Yes. Frank Palumbo of the School of Pharmacy gave me all of that information last week, which is in the trunk of my car in the parking lot outside. I will get it to you.

DR. WOLF: Thank you.

JUDGE FADER: Okay.

MS. NICHOLS: The DEA website that Mary referred to, also DEA Diversion website, also has a list of all of the states with PDP's and when they were implemented.

DR. WOLF: Well, the other half of my question is these states that are now enacted or actively processing their enactment, are we able to get ahold of the problems that they're having, or the things that they're running into as they're actually implementing and selecting data?

MS. ROCHEE: I've, I've reached out to a couple of the states -- Ohio and Kentucky -- because they've been in existence, and I will tell -- and, actually, I had a long discussion with Ralph Orr at the time and they have been very yielding as far as wanting

to support other states coming onboard. So I think any, anyone that you reach out to, you'll find they'll be lobbying in this.

JUDGE FADER: The University of Maryland School of Pharmacy tried to do something to ascertain this information last year. They estimated that they would need a four-hundred-thousand-dollar grant to obtain this information. They got turned down.

Okay. So, according to Dr. Palumbo and the people in the Drug and Policy Division of the Maryland Pharmacists Association, what you're asking is going to consume a considerable amount of time to accumulate this information, and they don't have the money to do it at this point.

MS. ZOLTANI: By the way, out of the 20 -- out of the 38 states, 29 have operational of PDMP programs. I have a map. I didn't bring it in.

DR. WOLF: We have it.

MS. ZOLTANI: It's -- oh, okay.

DR. LYLES: From, from pure law enforcement point of view, 'cause that's the way, that's what we've focused on today.

MS. ZOLTANI: Yeah, that's --

DR. LYLES: Are you guys collectively seeking a patient specific access, or are you, do you want to

go to, what, a broad, multi-variant database with search capabilities and data-mining, and things like this and so forth?

MS. NICHOLS: Yeah.

DR. LYLES: This is what you want?

MS. NICHOLS: Yeah.

DR. LYLES: That's what I was afraid of. Okay.

MR. REILLY: Part of, because everybody, every, every level, somebody will have a different interest.

DR. LYLES: Yes. Because if you look at -- I put something out here on database -- if you look at, the last two pages of that is, is, with reference what is, our insurer's doing and what they're using ths national database for -- which are SureScripts RSF, is to data-mine using Milliman and Company and Ajenics (phonetically) to exclude patients from insurability.

So there lots of avenues that this so-called database on a national level or a multiple and regional level can take. And none of us want to see it, see it go there. So we want more protections -- at least I do. And I'm speaking for myself now.

JUDGE FADER: I don't think you are. I think you are speaking for almost every one of us in the

room, but go ahead.

DR. LYLES: And I would be absolutely opposed to you having a broad multi-variant data-mining search capabilities as law enforcement. I think there are other ways that need to do things. My colleague in the back here says sometimes it's better to go slow --

MR. SHELLENBERGER: Well, one of the, the things we had discussed was --

DR. LYLES: -- and surely.

MR. SHELLENBERGER: -- that in order for us to have that search capability, there either needs to be an active investigator. The people who have monitored the database have seen such trends that they cause them to contact law enforcement.

DR. LYLES: Mm-hmm.

MR. SHELLENBERGER: So, so there is a two-step process that we're proposing. And, so, if Mr. Reilly has a very specific case he's investigating concerning a very specific patient, or a very specific office, he's going to need some level of cause to go to the keeper of the database and say, This is what I need and here's why I need it. Or somebody who is monitoring the database to say, oh, my God, nine million Oxycodone going out in 22 months, I need to tell somebody.

JUDGE FADER: But, Bob, aren't you mostly

concerned with keeping, not that, but with keeping it out of the hands of people who may jump in as employers with regard to insurability? That's what he's talking about --

MS. NICHOLS: It's, it's important.

JUDGE FADER: -- not a lack of faith in you.

DR. FARAH: Right.

JUDGE FADER: But to insure the database is not otherwise available.

DR. FARAH: Or hackable.

DR. WOLF: Certainly doctors.

MS. NICHOLS: Because what you're talking about is a national problem.

DR. LYLES: What I'm concerned about is the general community --

MS. NICHOLS: Right.

DR. LYLES: -- with a gotcha syndrome. You know, opiates are looked upon as evil. Blood pressure medication, which has a high, far higher rate of complications, are not looked upon as evil.

But from an opiate point of view, we have this situation in the community that people, if you're on Oxycodone, it's simply not quite right.

JUDGE FADER: I have to take a 10-minute break --

DR. LYLES: Sure.

JUDGE FADER: -- at the next good time.

MR. SHELLENBERGER: Well, and, and to finish that point, up --

DR. LYLES: Sure.

MR. SHELLENBERGER: -- and, I mean, you are here to create Maryland statute, and you have the ability to suggest what protections need to be there. And while I don't write statutes, I've read them and you can, you can deny access to --

DR. LYLES: And --

MR. SHELLENBERGER: -- to assure companies, or to mandate their civil penalties to the database that are disclosed to company. And they used to exclude people insurability and make them become --

JUDGE FADER: And Federal laws on the book --

MR. SHELLENBERGER: Right. Right.

JUDGE FADER: -- that prohibits much of it.

MR. SHELLENBERGER: Right.

DR. LYLES: Two minutes of dialogue.

MR. SHELLENBERGER: Right.

JUDGE FADER: Two minutes. Two minutes.

MR. KOZLOWSKI: And then have a, I have a question about cost effectiveness.

JUDGE FADER: Okay. We're going to -- just a

10-minute break, for bathroom break.

DR. LYLES: Very good.

JUDGE FADER: No, go ahead.

MR. KOZLOWSKI: No. I'm interested in cost effectiveness because when I'm noticing and, when I take a look online, is a lot of, a lot of data online, and I think this makes a different -- see, one thing about pain reliever medications in some states, but it only goes to 2003. I realize that this is just the beginning, but I'm not impressed with whether it really makes a difference, whether it's too much of a flurry of activity. But I think there, from your -- I just want to talk about the indicators that you would have, that this really makes a difference.

How would you -- what kind of indicator would you pick to say that in states that really have a fully-developed prescription monitoring program we notice an absolute decrease in the Diversion that we aren't having? We aren't getting the kind of reports we used to. We think we've got this under control. Do you have any confidence in saying that right, now knowing, not knowing what the, the standards of Diversion would be? I, I don't, we don't have one in Maryland so I can't speak to that, but I would -- I mean, in other states, what do you know?

MS. NICHOLS: But I think Kentucky could certainly speak to that. I think that other states with, with PDP's that have been around for a while could speak to that.

Mary, what do you think?

MS. ROCHEE: I think from, from where we are in Virginia, they have some evidence that it's been helpful. And I would, will say for cost effectiveness, first of all, generally, when -- and when the Department of Health professions' inspectors were going out to follow up on complaints -- and those follow-ups might involve them going to a doctor's office, or to a pharmacy and to look at prescription records -- from a cost effectiveness perspective, generally, they might send one or two investigators out. It's going, it's going to take those two investigators probably some time to visit so many pharmacies, which is a certain ZIP code, or a certain perimeter and flip through the prescriptions, talk to pharmacists. That's a lot of man hours, a lot of legwork to do. I think that cost effectiveness factor speaks for itself; okay?

And the same for, for the investigator. As I said, we might go out and send five people out to hit 15 pharmacies, and it could take them two, three days, or a week, to accomplish that.

MR. KOZLOWSKI: Mm-hmm.

MS. ROCHEE: And they need to come back and look at the information you have, sort it out, then input into a computer, try to make some manageability sense out of it. So, with that, I think it's a, definitely a win-win.

MR. KOZLOWSKI: Yeah.

JUDGE FADER: Can everyone be pack here, then, at 11:15? We don't plan to go today too much longer than 12:30 or 1:00 o'clock, because we know you all have things to do.

MR. KOZLOWSKI: Okay.

JUDGE FADER: Okay?

DR. COHEN: Thank you.

JUDGE FADER: See you at 15 after.

(At 11:01 a.m., the hearing was recessed and resumed at 11:14 a.m.)

JUDGE FADER: All right. Can everyone please come back? Now, what we're going to do is, we're going to run 'till 11:30, maybe 11:35 with some more questions here, then we're going to thank these people for coming and then we're going to listen to Linda Bethman and Tom Keech, the attorneys for the Disciplinary Board. What I expect to come out of this meeting is a transcript, plus, with the help of some of

my students, something that's, says these were the questions that were raised here, okay, and then we'll see what we can do.

All right. And if we get all of your e-mails, we will send you all a copy of all of this, too.

MS. NICHOLS: Wonderful.

JUDGE FADER: All right. And more questions?

DR. MARTIN-DAVIS: Yes. I just have two questions. One of the things that's very frustrating for us in the real world is trying to find a way to, to catch patients who go to Giant Pharmacy with their prescription card, and then go to CVS and pay cash. So a big question would be how would this database allow us to monitor those patients? And probably -- you know, I'm assuming that those doctors you were talking about where the woman was going pharmacy to pharmacy, she was probably paying cash at two or three places --

MS. NICHOLS: Mm-hmm.

DR. MARTIN-DAVIS: -- and using her insurance. So that would be one thing I'd be curious to know, you know, how we can get a handle on that. And, second, having realtime information with -- we get information that people are doctor-shopping two and three months later then, yes, I feel, obviously, vulnerable and frustrated.

But, more importantly, I'm thinking, okay, now you guys have this information. And a lot of times, you know, Doctor, why didn't you know this? So if I have realtime information, I can maybe catch this -- catch for lack of a better word -- this person when they come into my office, if there's something that I can pull up before I fill their scripts.

MS. NICHOLS: Mm-hmm.

DR. MARTIN-DAVIS: Now, we have a program in our computer that allows us to see all the pharmacies with some patients, but not every insurance company participates and we have to put in some data, ourselves, which is manpower and time, but -- we can do that to a certain extent -- but if you're talking about a statewide or a nationwide database, you know, would that allow me to get that information, really?

MS. ROCHEE: I'm going to start off on the realtime question. I think that's going to depend upon how the database is, is put together, okay, and what, what criteria the planning group, the planning group here pushes as far as part of what's being legislated; okay? I think we should probably look at those states that have existing programs, and go out and see what happens with the prescriptions in terms of realtime availability, how feasible it is. Because feasibility

of things are going to determine what we end up getting in this, in the State of Maryland, obviously.

With regard to patients who may pay with their Medicaid card and pay cash at different pharmacies, for DEA, we generally don't have access to that information unless we go into a pharmacy and physically look at information. A lot of times we can't tell how someone paid for their prescriptions. Neither are we entitled to that information. We, we are entitled to information regarding the controlled substances; okay? Payment information, sometimes, that State is marketing data, it's something that we are not entitled to obtain, so I really can't speak on pricing information. But I will tell you the prescriptions, themselves, tell you specifically. We pull up a physical prescription, it makes it clear how the prescription was paid for.

MR. SHELLENBERGER: But the, the data would go into the database, no matter how they paid for it --

DR. MARTIN-DAVIS: Yes, that's my, yeah, that's my question.

MR. SHELLENBERGER: -- so --

DR. MARTIN-DAVIS: So I know they did buy it regardless.

MR. SHELLENBERGER: So if you go to Giant with your prescription card, it goes in as -- your name is

there -- as I indicated, numeric identifier. If you then go to CVS and pay cash, your name goes in and some kind of numeric identifier, you know, you get into all kinds of issues about, well, what if you send your kid to pick the prescription of.

But, you know, what, what we're trying to do is, is -- I always like to try to figure out in life is how do I capture --

MR. REILLY: Are going to be able to catch --

MR. SHELLENBERGER: But they would go in the, the database and --

JUDGE FADER: And the gatekeeper would have, whoever the pharmacy is, looking at this. And you have in --

MR. REILLY: Too, if someone goes in a, hits three pharmacies in the pace of one hour, you're not going to be able to capture that. But you're going to get someone who goes, maybe, on a day-by-day basis or a week-by-week basis, and that's the one you're going to capture. That's, that's 90 percent.

MR. SHELLENBERGER: But a month later, you would be able to look back and say he got three of these prescriptions a month ago all in the same day, and, and that's when your radar goes off.

MS. NICHOLS: Right.

MR. SHELLENBERGER: Yeah. So John's right. Yeah, three places in a two block -- area of an hour, they're going to be, because a month later you would know --

MR. REILLY: Right. I, and a pharmacy -- and you're going to say this person received 100 Oxycodone pills every day for the last 30 days; why am I filling another prescription --

MR. SHELLENBERGER: Right.

MR. REILLY: -- on this 31st day? Those are the things you're going to have that are going to help you and help us.

DR. FARAH: And what would be very helpful, if we can learn from the fellows that work on that before, is who is really looking to see if 100 tablets of Oxycodone 30's is or is not appropriate. Who is going to look to see if the, another hundred of Percocets for the same patient and the other is not appropriate. It, it is more than just a sheer number, unless the number is absolutely ridiculous. Because we've had the experience of -- several, several times we have our investigators bring us a last look at this. It's outrageous. And you really look at it and look at the condition. Well, if it wasn't that, it wouldn't be proper medicine. And, and it looks outrageous. Who's

going to look at this before we start the full-blown investigation. This is something we need to know how other people have addressed. And, and what, what are the, the areas in the, in the health care field that we need to point out before we start this, this, this six-month, seven-month investigation for something which may not at all be an -- appropriate.

So what kind of software do we have to sort out that it, the red flag -- and who's going to look at the red flags? Who, who is going to look at the red flags to decide, you know what, we do have a problem? Let's then --

MR. REILLY: We're not -- the, the whole idea of the database is not we're going to make a determination on these medical calls. It's this person who's gotten 100 tablets 10 times in a very short period of time. I mean, certainly our investigators have called the doctor a couple times and, and said, hey, this is a prescription; it seems odd because a pharmacist called me and thought it was odd that they were paying cash at 9 o'clock on a Sunday night for these hundred pills, and, and they'll call the doctor as part of that investigation.

I mean, I guess there's no way to say something would never happen, but that's why the

investigation has to take place. And that's not our goal, to do that. If you want to use database for kind of a twin goal -- I mean, it can be used for many purposes -- and if there is somewhere in the Board of Physicians that wants to try to regulate what is good care and bad care, that's not where we are. We're not close to that line. That's, that's not where we're trying to get to. We don't want to get into battles in Court where someone is medically capable of having this many pills within that certain period. We're not near those.

MS. NICHOLS: Medical necessity cases are very, extremely difficult in health care fraud investigations. They would be equally difficult in Diversion investigations, if that's what it's going to come down to.

So, you know, we do use expert witnesses so that -- that's not to say that someone, that an investigator's not going to come to you and say, with a subpoena and say I want these three charts and we're not going to have them reviewed by a physician. That could very well happen.

But, you know, we're not going to be looking at close calls. I just, I couldn't agree with that more.

MR. SHELLENBERGER: I, I mean if I, as a prosecutor in a State Court, have to call a doctor to comment on whether this is medically germane or not in a criminal case, then I am wasting my time. I mean, I absolutely -- I, I mean, that is something for you, actually, to do at the Physicians Board.

DR. FARAH: I appreciate that.

MR. SHELLENBERGER: And that is not something that I think any of us have a desire of doing. Yeah?

DR. FARAH: I appreciate that. And that's what we do, and that would be a duplication of work, which is not what it's all about.

MR. SHELLENBERGER: No. That's your job.

DR. FARAH: My, my concern is the, how many potential investigation agents --

MR. SHELLENBERGER: Right.

DR. FARAH: -- are going to go on for no valid reason.

MS. NICHOLS: I don't think --

DR. FARAH: That is my concern.

MS. NICHOLS: -- I don't know that you're going to see more investigations. I think you are going to see better investigations; I think you're going to see more appropriate investigations; I think you're going to see more timely and more efficient

investigations.

DR. FARAH: And that is the data that Dr. Cohen brought up very well, to see do we have it, experience; is this happening? Let's take a look at it and see what it takes to, to, to get that happening because of our location.

MS. NICHOLS: Right.

DR. FARAH: Because we're dealing with four other states around us that, that feed into our health care system, and, and this is what, this is the information we need from, from our fellow people who have done this before --

MS. NICHOLS: Right.

DR. FARAH: -- so that we can make sure we're doing it right.

DR. WOLF: One of the things that I think may make a lot of us, especially clinicians, feel better but, unfortunately, is beyond the scope of this particular legislation is an educational program not just for physicians, but for the public in general. We at -- attempting to do some of that through medcog, but it's such a big job and funding, of course, is always an issue.

But some of the statistics you quoted were, I think you said, I think, between the age of 45 and 54

accidental and overdose deaths now surpasses MVA deaths. What we don't have, a cause-and-effect relationship to any, to any of this.

MR. SHELLENBERGER: Right.

DR. WOLF: The other thing that is Class IV, the C-IV drugs now getting into the hands of the teenagers. Yes, we'll be able to track some trends as to whether an individual, an adult or a teenager, whatever, is filling multiple prescriptions, but that doesn't stop the legitimate prescription being filled being in the medicine cabinet and some teenager going and taking it out of the medicine cabinet.

And, so, I think what needs to happen hand in hand is that the public needs to be educated as well. And, unfortunately, as I said, that's beyond the scope of this particular legislation.

JUDGE FADER: But not without the scope of a footnote that tells the Legislature we need this and we need money for it.

DR. WOLF: Yes.

DR. LYLES: One other comment.

MR. KOZLOWSKI: Are these 38 states --

JUDGE FADER: From a person in addiction, do we have any trend data on the number of prosecutions and investigations before and after implementation of

these programs, and whether any particular specialties are more vulnerable to being investigated?

MR. SHELLENBERGER: Again, I think that might be something we're going to have to get from one of the folks who knows, you know, a little bit more about each of these, each of those different databases. I mean, it's my understanding that, that one of your co-worker, co- -- what do we -- commissions --

MR. KOZLOWSKI: Committee.

JUDGE FADER: Advisory Council.

MS. ZOLTANI: Committees.

MR. SHELLENBERGER: -- committees is trying to get someone, one of those agencies to come in and try and answer some of these questions. But I think that's a good question.

JUDGE FADER: Okay.

DR. LYLES: Where does the DEA stands on the prescribing now? You know, Medicare is mandating a -- prescribing, I mean, in about 2010. So how are you guys going to handle Class II through IV drugs you prescribe?

MS. ROCHEE: You know, I, I don't have a direct answer to your question right now. I know that at this last meeting there was a Federal Register notice out, and I believe they were in comments of the

last night notice that I heard. And I don't have any more recent information on that that I can -- I'll be glad to get back to you on it, if you want some follow-up. But I, the last thing I read on it was that the Federal Register notice was out for comment.

DR. LYLES: Okay. So it's just --

MS. ROCHEE: Is anyone else seen anything about that? That's what --

DR. WOLF: Other than the fact that Medicare now has codes, which include a, a code that is, I think it's 8446, which means that you couldn't give the patient the pre- -- do it electronically, because it was a controlled substance.

MS. ROCHEE: Right.

DR. LYLES: Mm.

MS. ROCHEE: But I'll be more than glad to get back with you on that; okay?

DR. LYLES: (Nodding head yes.)

JUDGE FADER: Anybody else? Well, thank you all, very much.

MS. NICHOLS: Thank you --

MS. ROCHEE: Thank you.

MS. NICHOLS: -- for having us.

JUDGE FADER: We have a lot of work to do and a lot of questions to ask you. And I am presuming

there will be a number of questions from you to us, but we appreciate it. You're welcome to stay, welcome to go. Do whatever you want to do.

We're going to hear now from Linda Bethman, who is an attorney for the Board of Pharmacy. And, probably, she's going to get Tom Keech, who is for the Board of Physicians here, and listen to what they have to tell us with regard to their, their problems. Thank you all, very much.

MS. NICHOLS: Thank you for having us.

JUDGE FADER: And we will have all, everything sent to everybody here electronically, including the transcript.

(Pause.)

JUDGE FADER: Linda Bethman.

MS. BETHMAN: Do you want us up front, Judge?

JUDGE FADER: I certainly do.

MS. BETHMAN: Okay. Hi all. Linda Bethman. Again, I'm with the Office of the Attorney General. Judge Fader had asked me to get some representatives from the Physicians Board and the Pharmacy Boards to present to you today so we have a synopsis of their investigative process, the types of cases that they look at, their investigative protocols, the information that they currently have access to and how the creation

of this database would affect, one way or the other, their investigative process.

I have ingeniously delegated my presentation today to Dorcas Ann Taylor, who is the Pharmacist Compliance Officer with the Board. She's an attorney and Pharmacist and she overseas all of their investigations.

Also today is Tom Keech, who is a colleague of mine at the Attorney General's Office. He's a Senior Attorney and Board, Counsel to the Board of Physicians and he will speak to you with respect to the Board of Physicians' protocols and some of their recent cases involving physician-dispensing irregularities, I guess, I should say, so --

JUDGE FADER: This is the first time I've listened to Tom Keech that he hasn't been going down the Board -- Court of Appeals to get me reversed.

MS. BETHMAN: I don't know which one of you wants to --

MR. KEECH: Why don't you start?

MS. BETHMAN: Okay. Ann?

MS. TAYLOR: If it's okay with everybody, I'm going to stay seated, 'cause I, I really wanted to start off by just giving you an overview of what the Board of Pharmacy does so you can understand what the

mission is. And then, and then I'll talk a little bit about, maybe just a, the way we process through a case.

The Board acts to prevent -- protect Maryland consumers, and, and we do this by promoting our quality health care through licensing of pharmacists and the pharmacies and also by issuing permits to various types of establishments, like pharmacists, as well as wholesale distributors. We also set standards for the practice of pharmacy and develop and enforce regulation and legislation. We receive and resolve complaints and educate pharmacists and consumers.

And the Board is made up of 12 Commissioners. Two of, two of those Commissioners are consumer members, 10 are pharmacists. And then there's the staff of the Board, which includes, in, in smaller parts, the Compliance Unit. There's a, there's a large group of people, but in that group there's Compliance Units, and within the Unit there is investigators as well as inspectors.

The, the inspectors will go into a pharmacy. And we have certain standards that we anticipate that the pharmacies will meet. As part of that, we also look at certain controlled drugs monitoring the way that the pharmacy is dispensing them to make sure that they are complying with the various laws. But then, at

times, the pharmacy inspector may note some red flag within that inspection, and some of those red flags may be that we have a physician that's prescribing only controlled substances, maybe, to cash-pay customers, and the physician, physician is prescribing by way of the Internet, and the prescriptions come by, are provided to the patient, as I say, by mail from the pharmacist. The pharmacy may have gotten, maybe, 100, or a, hundreds or thousands and, and these, this kind of makes the inspector, just gives the inspector, like a red flag that something, something's unusual here.

And, from that, the inspector will look a little further and maybe do an investigative inspection to learn more about what's going on. The, usually in those cases we find that the physician has not had a face-to-face relationship with the patient and, as a matter of fact, the physician may be out of state and the pharmacy may be sending prescriptions to patients throughout the country, so not just Maryland.

Another significant or red flag for the inspector may be that the patients are all, a patient may be all cash-pay. That's a, that's a harder finding, because they're actually looking at a prescription. But as they're looking at -- they may note, because one prescription over and over again is

cash-paying and, so, the pharmacy inspector may ask the pharmacist a little bit more about what's going on with this particular circumstance.

The, the pharmacy may also be -- may not be providing services to populations that it actually states that it's providing. So, for instance, it may say that it has a long-term care population when, in fact, we don't see any long-term care contracts or relationships, but we see the movement of the controlled substances coming into the pharmacy and then going out. Where is it going?

So those are kind of red flags that would lead the Investigative Unit and the inspectors to want to find out more about what's going on.

The Board would obtain the information that it will get from the inspectors of the, this type of nature, but it could also get information by way of some report from, let's say, a company or from an individual and, and, from there, we would look a little further at what's going on with a particular circumstance that, that is reported to us.

We may also get information by way of a subpoena if we're looking at, once we do the investigation, we want to know more about what's going on. So, so the Board has subpoena power or authority

to get information.

The Board uses that information to, to work up an investigation, but it may also use information that it is able to acquire from the FBI or the DEA as we work together with cases.

It may also get information from State regulatory, other State regulatory Boards within the State, or other State Boards or pharmacies outside of the State. And the information is also available, of course, from the Board internal files that we're, that we're retrieving.

All of this information that we're retrieving we are, are using to evaluate cases that we are looking at for a standard of practice, or standard of care investigations for these pharmacies and pharmacists. Not really patients as much. Although what happens and is a challenge is that many times there may be a patient that is involved in the, in the Diversion of the drug. And the, while, while the Board is looking at the pharmacist and pharmacy, there isn't really much beyond sending the information to law enforcement that we can do with what we find in terms of these sporadic kind of, the sporadic information that we find with the patient.

The, I think that one of the, one of the main

issues that the Board is finding that may be significant, a significant concern is that the pharmacies are starting to contact us and asking us, you know, if there is a patient who they know is doctor-shopping, or is using fraudulent prescriptions or what do they do with those patients. Some pharmacies that are on the border states, border of, of the other states, have actually become registered with the Prescription Drug Monitoring Programs for those borders and, and, so, they're able to link into Virginia, especially.

We talked about Ralph Orr. Actually, his office has been very friendly with us lately because we've had to actually refer those pharmacies to the, to the Prescription Drug Monitoring Program so that they can actually link in.

We've done some of the same type of things with West Virginia. And the pharmacies have, have been very, they, they've been very appreciative. Because while they may have, well, while we may have information about other pharmacies, we really don't have that information about the patient population. And sometimes they call and, and they are giving us that information about those patients, but they also give us information about forged or fraudulent

prescriptions. And those forged or fraudulent prescriptions, it, it tends to look like a doctor is actually writing, you know, a significant number of controlled substances, prescriptions for one patient. It could be an office manager; it, it could be quite a, quite a, a wide group of people; it could be different names or it could be one person as a patient name, or it could be many names. And, and the problem that the pharmacist sees is that they really don't have a way to address what's happening with the patient, you know, as much. So I think that one of the areas that will be useful for the Board of Pharmacy and for the pharmacist when we, when -- and I, I guess I was speaking prophetically -- when we have a Prescription Drug Monitoring Program, we'll be able to assist both the physician, so that when there is that, that forgery type of situation or when there is that patient that is doctor-shopping, that they have a, the, the pharmacies have a better way of targeting or, or identifying the patient and then being able to address whatever the concern is for the patient.

A lot of what was said earlier with DEA I didn't address, but -- because I didn't want to repeat a lot of what they had -- was a lot of their investigation process is quite similar to what the, the

State Board of Pharmacy does. One thing I will address is that run to daylight. We actually are, as DEA say, daylight. And what, what a lot of individuals will do, as, as I said, they will come to our, our State from a lot of the other bordering states. And, so, even though those border pharmacies are getting their registration so that they can get involved with the Prescription Drug Monitoring Program, what, what we're still finding is that daylight just means they're moving further into the central part of the State.

So, I mean, you know, I think that the Board will be, be very interested in and they strongly support implementation of the Prescription Drug Monitoring Program. And I think one of the things that will be useful is, as we move forward with this is to review legislation to make sure that we have some of the, some of the same confidentiality type of controls that a lot of the other states, especially Virginia, has.

I spoke with Virginia's Prescription Drug Monitoring Program -- I'm not sure if she was actually Ralph Orr's Assistant -- just to get a little bit more information about how they, they work through the confidentiality. And they actually do not have patient names, as much as the unique identifiers, for those

individuals so that they're able to keep the name kind of close to the chest and not really release too much information about the patient to the people who would access, actually, the database. So that you can see that, the information, but you don't actually see that patient name unless there is a true need for it. And then you would have to go through the office to get a little bit more information about it.

DR. WOLF: Are they using health insurance numbers or Social Security numbers?

MS. TAYLOR: I'm not sure what those unique identifiers are.

MR. KOSLOWSKI: If you may, if you will, please, what type of collaboration is going on between border pharmacy and the PBM's, either for the large plans or for self-insured?

MS. TAYLOR: The Board of Pharmacy, itself, does not collaborate with the PBM's to -- we, we don't have any type of Prescription Drug Monitoring Program. I'm not sure if, if you're going to ask me --

MR. KOSLOWSKI: Only meant from a referral standpoint, not the exchange of, data exchange. But, I mean, they obviously are doing very much of this, they're doing much of that, themselves. There's -- a lot of investigation goes on within the plans --

MS. TAYLOR: Okay.

MR. KOSLOWSKI: -- you never hear about for all kinds of reasons. And, so, they're trying to hold back costs as well.

So there are, there are different silos (phonetically) in operation. I was just wondering if there was a collaborative communication link. And, and that's something we might want to consider --

MS. TAYLOR: Mm-hmm.

MR. KOSLOWSKI: -- because the use of PBM's, the authority of PBM's and the efforts have accelerated exponentially in the last 10 years.

MS. TAYLOR: When, when the plans perceive that there's abuse, they will send us a complaint or they will send us information that we can investigate on further. And it may be that we actually will send -- well, we'll investigate that Complaint based on the pharmacy. But where it is a patient, we may forward that to law enforcement. And where, where it is a perceived prescriber, we would also forward it to the respective Board for the prescriber.

I will size up, also, to let you know that the, the Maryland Medicaid does have a pseudo, kind of Prescription Drug Monitoring Program which is called the Corrective Manage Care Program where they've

actually identified people who have, have triggered a little higher as far as their controlled substance use, and maybe they have several doctors that they use to provide them with prescriptions. And they will communicate with the prescriber and, to let them know that. And possibly some of these physicians here may have gotten those nice little letters to say, hey, your patient is using quite a few different controlled substances; you want to investigate this a little bit more?

And, so, they have been able to provide the Board of Pharmacy with the data, as well, when they find that there's one particular pharmacy that is where that patient is going to, or those patients going to. And, so, so we really don't have -- beyond, beyond getting those complaints from the, the PBM's, we, we will also get the information from the Medicaid program.

MR. KOZLOWSKI: Thank you.

DR. WOLF: Actually, a lot of what we get from the Medicaid Program we get cost-based data.

MS. TAYLOR: Mm-hmm.

DR. WOLF: We don't necessarily get numbersm or quantities or varying prescriptions. But it's all based, it's all cost-driven.

MS. TAYLOR: Okay.

MR. KEECH: See it just says so much dollars.

DR. WOLF: Can you prescribe the cheaper drug?

MS. BETHMAN: Yeah.

DR. WOLF: I have. Can you give me something cheaper? Do you know how expensive this, this --

DR. FARAH: Yeah, but the SureScripts has been very helpful, because I do get periodic letters saying you have this patient on Oxycodone and Percocets, what have you -- and that's been tremendous. Because, then, if he would have gone to an out-of-state -- but the SureScripts would, would have sent that information, so sometimes it is very helpful.

DR. WOLF: (Nodding head yes.)

MS. TAYLOR: (Nodding head yes.)

MS. BETMAN: And, and can I interject?

MS. TAYLOR: Mm-hmm.

MS. BETHMAN: Just -- and an important thing to note with respect to the, the evaluation of the data that is presented to the Pharmacy Board at present is that it is a regulatory agency that is, reviews virtually all of pharmacists. It's pharmacists reviewing the data with respect to the standard of practice of pharmacy. So you do have experts in the field.

I know there was some concern, before from the law enforcement perspective, that you know who's evaluating this data; do they even know what they're looking at? And with respect to, least the, the professional boards, we hope that they're looking at it, because that's pretty much their job -- that they have the expertise in the standard of practice so they, as far as the filtering system, or that buffer between the, the database and the access by the Agency to the database, that would certainly be something we would discuss as to whether that buffer needs to be there or in the regulatory agencies.

MR. KEECH: My name is Tom Keech. I'm with the Attorney General's Office, and I represent the Board of Physicians. And unlike everyone else that has spoken, I would be flattered to be called of medium age.

The Board of Physicians is, is not on the front lines of, of this problem. I just -- we're not, you know, responsible for what's happening in an, Emergency Rooms dealing with immediate overdoses, et cetera. But neither are we as far removed from it as law enforcement. Kind of in the middle.

The Board, the Board's interest is enforcing the standards of care where physicians have, where

physicians are treating patients and, hopefully, improving it in the process. And in rare cases where there really are emergency, the Board can summarily suspend a physician if it thinks an imminent danger to public health is created.

So the Board is interested in those two processes. It's a little closer to the front lines than law enforcement, a little further back than the physicians and the Emergency Room.

The Board is a complaint-driven body and received over 1200 complaints every year. It has a difficult time dealing with that many complaints and does not go searching for any more work to do.

A, a significant number -- I don't know what the percentage is; Carole Palmer was going to be here from the Board; she's the Intake Supervisor, and she knows more of the nitty-gritty details. I got as many of them as I could for her, but she was ill and she couldn't be here today -- a significant number of our cases do deal with overprescribing or alleged overprescribing.

The sources of our complaints are, the main source is family members. Often the family member, after there's been a death in the family; occasionally colleagues, when colleagues are reporting as often

with, that a physician is self-prescribing and it's noticed by a colleague and, on rare occasions, pharmacies, themselves, have complained to the Board; we, on rare occasions, get complaints from insurance companies who have noted patterns or trends.

They, from what I hear here today, they must go more to the Pharmacy Board than they do the Physicians Board. And what the Board's concerned with is, primarily, the standard of care. Not how much drugs are given, but how well they are given. And that is judged on the first level -- usually buyer, a consultant, then usually by a panel of the Board. Then it's sent to two independent peer reviewers, and they're, they're concerned with the standard of care.

On a preliminary investigation standpoint, a case is likely to raise a red flag if there's some clues that a physician -- for example, if a physician does not do any physical exams but simply prescribing drugs prescribes CDS on the first visit for some vague pain without any attempt to deal with it by non-CDS and prescribing an overlapping amount, such as 30 days of Oxycodone, three tablets a day on January 1st; 30 days of Oxycodone three tablets a day on January 3rd; 30 days of Oxycodone three tablets a day on January 5th. Something like that would raise suspicions but, in any

case, it would go, have to go to a peer review.

Now, as far as this database goes, it would, certainly would aid the Board's investigation and speed them up. The Board has been the subject to a lot of criticism for slow investigations. In fact, as we speak, a task force on the health occupational boards is trying to develop guidelines and limits within which the Board must complete its investigations. Something like this database would help. That's the primary way I think it would help the Board.

The, what the Board can do, though, when receiving a complaint is subpoena. We use just a legal process. We subpoena pharmacy records. It's very easy and works very well if it's a chain pharmacy. If it's not, but we don't know and especially if it's the patient, or the patient and the physician are basically working together to stay under the radar, it's very difficult. But what the Board staff does is that it tries to locate all the pharmacies that are around the physician's office, tries to locate the pharmacies around the patient's office, sends individual subpoenaes to them. They, they don't want to issue more than six to eight subpoenaes in one case because they just, they just don't have the resources to do that. So it's a little bit of guesswork.

And I'm not going to repeat. You obviously heard here people are clever. You know, we have patients in Rockville who are filling their prescription in Elkton. We have doctors who -- this is another red flag if a doctor tells the patient don't fill it at that pharmacy. We have that a lot, too.

MR. KOZLOWSKI: Would you --

MR. KEECH: We have a lot, too. So the database, the Board thinks, would be a help to eliminate the guesswork. And in another area and a little closer to the front lines, to permit follow-up.

An example I was given was a doctor we have in Baltimore who had eight patients for whom he was prescribing CDS died of an overdose of CDS. None of those cases were found by peer review to be a violation of the standard of care. And it seemed pretty obvious what was happening if the patients were getting, perhaps, an appropriate amount of CDS from this physician, but inappropriate amounts or additional amounts from other physicians. We don't have the resources to be able to track that down. And if we had that we could know that.

And the Board is also interested in the quality of medical practice besides disciplinary people. And I, I think the Board would very much be in

favor of having a physician who is treating a patient to, especially a patient in pain management, but, but any patient who is being prescribed CDS to be able to go to the database and see if that patient, if he is only one of five physicians who is currently prescribing, if the patient's going to other, other physician, other physicians.

So the, from the investigative point of view, the Board stands somewhat in the middle. We can do investigations without this database. We think we could do much more thorough investigations, and a lot quicker, with the databases.

And as far as improving the quality of medical care and improving follow-up on trails of apparent overprescribing or doctor-shopping, we think it would be very much a help. And that's all I have. Thank you.

JUDGE FADER: Tom, let me ask you a question. I -- the Board of Pharmacy had the pharmacists -- and the regulations as a brother's keeper regulation, which means that a pharmacist is required to report another pharmacist who has CDS problems. If they don't, then they could be disciplined. Does the Board of Medicine have anything like that?

MR. KEECH: No, it has --

JUDGE FADER: Okay.

MR. KEECH: -- it has nothing like that.

MS. HERMAN: I, I was wondering if there was any education involved of the doctors.

MR. KEECH: In what sense?

MS. HERMAN: Of what they are allowed to be doing, or what they aren't supposed to be doing or if there's any new complaints coming up, if they're provided with that so they understand that, you know, these, there are certain limits that they're not supposed to go over, or --

MR. KEECH: Actually, the Board created a movie, a video that, called A Sense of Balance that is precisely on, on that point, and only that point. What we -- you know, when you have, when -- what are the warning signs of a patient who is manipulating you; what are the warning signs of a patient who is doctor-shopping; when should, should you be concerned? And is that what you're talking about?

MS. HERMAN: Yeah. Yeah.

MR. KEECH: And that is still available and the Board has used it. And we used to use, we used to do in-person orientation. It was required when a physician first became a physician or, at least at the first renewal they had to go to orientation. So it

used to be shown at every single one of those. However, the orientation is now done totally online. So it's, it's not, no one is forced to see it, but everyone, anyone can see.

MS. HERMAN: Mm.

MR. CLARK: I have a question, I think, for the, for the Board, the Pharmacy Board is, do you find -- and, and I think that the other things that, that you've discussed certainly point up a need for this, for our having a PDMP, but do you find that because we do not have that and the surrounding states do, that we -- you hear in the other boards that, you know, these people that are getting, that are abusing prescriptions, obviously, they're -- haven't dealt with them -- they're pretty smart people, too, and they are going to be coming to Maryland and abusing things in Maryland because we do not currently have something that tracks this. Do you, do you feel that's the case?

DR. WOLF: Yeah. It's even more complicated than that. Because not only do we not have a means of tracking it, but you -- up until recently, we don't have a means of punishing them either.

MR. CLARK: Right.

DR. WOLF: There's nothing on the books that makes it a crime to doctor-shop.

MR. CLARK: Mm-hmm.

MS. TAYLOR: Definitely. The, the pharmacies are, you know, very concerned about the fact that we don't have the prescriptions with monitoring programs, and the other states are really concerned because they know that while, while the pharmacies in their state may not see the, who the patient is, the other part of the problem is the doctor who is experiencing the doctor shopper, but does not know that person's a doctor shopper, doesn't have the information in their system to know that that patient has gone to get several prescriptions from the colleague doctors and then filled them in Maryland.

MR. CLARK: Mm-hmm.

MS. TAYLOR: Because once they move to Maryland to get the prescriptions filled, then they don't see the information in the prescription monitoring systems in the state of Virginia.

MR. CLARK: Exactly.

MR. TAYLOR: So if, if they're not a registered pharmacist in Virginia, though a resident of Maryland, they won't get --

MR. CLARK: Sure.

MS. TAYLOR: -- the information that they need in order to get, to change the behavior of the patient.

DR. WOLF: Are the border pharmacies reporting these prescriptions into the VA system?

MS. TAYLOR: The Board --

DR. WOLF: The patients that come, in other words, basically, with their home State --

MS. TAYLOR: The border pharmacy isn't, but the pharmacy that is registered on that Board --

DR. WOLF: Yeah.

MS. TAYLOR: -- on the border is linked in as a nonresident pharmacy and as a participant in the prescription monitoring program they are reporting in. So they can see the data, yeah.

DR. WOLF: But are they reporting the prescriptions --

MS. BETHMAN: They're dispensing --

DR. WOLF: -- the prescriptions being filled to Virginia?

MS. TAYLOR: Yes, they are. Because they're linked into the system with the Virginia border pharmacy, so they're acting in, in the very same way as a pharmacy that is actually in Virginia.

DR. WOLF: Okay.

(Pause.)

MS. TAYLOR: They're linked into the system with Virginia.

MS. BETHMAN: And, and that brings up a point that was, I think, made up, made earlier, you know, about these mail order pharmacies. What do we do about that? And that's going to be an issue mabout looking at -- and, I believe, and looking at some of the programs in the other states, some of them do include nonresident pharmacies and some of them don't. So that would be an issue for the, Council to discuss. The Board of Pharmacy does license. If another resident pharmacist -- if you're a mail order in California, you're delivering scripts in, to a Maryland citizen, you got to be licensed here and there are certain requirements you do need to follow. For the most part, the rules of your home state. But there are certain requirements in Maryland that you do also need to adhere to, so that's going to be -- a big issue is whether you, you bring them into the loop as well, as far as reporting.

DR. WOLF: Can you put --

JUDGE FADER: But, of course, constitutional problems and commerce problems have surfaced with regard to out of the country.

MS. BETHMAN: No, no. Absolutely right.

JUDGE FADER: And we, we're not able to do anything about that --

MS. BETHMAN: Right.

JUDGE FADER: -- because of treatises, and commerce clauses and things of that sort.

DR. WOLF: Can you provide us with what the regulations are for the outside pharmacies --

JUDGE FADER: Yes.

MS. BETHMAN: Sure.

DR. WOLF: -- to provide for residents?

MS. BETHMAN: Absolutely. And the other question that I know that came up with respect to identifying the patients from -- and we get them now from pharmacists who call in and say, without access to a database, I know this guy is an addict; I just know it.

MS. TAYLOR: Yeah.

MS. BETHMAN: I'm going to turn him away. But do I need to do anything else with him? And that, those, those calls will be more frequent if they do have ready access to this type of information. Is there going to be an additional responsibility on the dispensers to either report him to a substance abuse program -- either way, to report him to law enforcement, or to just turn him away -- do they have an additional responsibility?

MS. TAYLOR: And then to tack onto that, then

who the, what do they also do as far as the physician who is, who was part of the doctor-shopping scheme of that individual? Are, what does the pharmacist do in terms of letting that physician know if they, they didn't access the systems?

MS. BETHMAN: Part of our, part of our initial discussion was about unusual first meeting. Take about using this database to identify addicts so that they could be treated.

MS. TAYLOR: Mm.

MS. KATZ: As opposed to being prosecuted.

MS. BETHMAN: Mm.

MS. KATZ: And making the physician aware whether it was their patient, a status patient or a patient that I had seen once had problem.

MS. BETHMAN: Mm-hmm.

MS. KATZ: Because we are looking at that as a medical problem as opposed to a law enforcement tool.

MS. BETHMAN: Mm-hmm.

MS. KATZ: And the aim which want to remember, that we're going to have plenty of patients who are basically in pain, who have legitimate needs for significant amounts of these drugs. So you, the balance issue is something that I feel the need to, to emphasize and reemphasize.

MS. BROCATO: I'm Barbara Brocato, and I represent emergency physicians and anethesiologists, just two groups. Not the only group here, but I, I just wanted to mention in terms of the balance and in emergency care, Judge Fader mention, mentioned substance abusers. The issue in, there's tremendous stresses and overcrowding in the Emergency Departments and it's associated with not having access to appropriate care. And to the point earlier, that as you look at this, you really need to look at patients' access to appropriate care. And the, the waits in Emergency Departments for a patient that arrives there, that has a mental health or substance abuse problem, is about four times the wait of an average patient. There's no treatment facilities; there are no beds in this State and that's the big problem.

So when you really look at this again, it's, there's such major treatment and, and access questions as you look at this, that I think it's important that this group really study them closely before moving forward.

DR. WOLF: Along with that, with regard to the Emergency Room data, one of the national or, one of the national pharmaceutical companies has a nonbranded program that's ongoing right now and it actually

discusses the treatment of acute pain. And data's been collected from hospitals, from Emergency Rooms, from, from nursing homes and they're starting to collect data from just average physicians. But what the data they already have shows, that the vast majority of people that go to the emergency room and go for pain leave with inadequate treatment. The overwhelming majority of them do nec- -- do not actually get any type of a narcotic. And if they do get any type of a controlled substance, it's not necessarily adequate to the type diagnosis that they're given in the Emergency Room.

They also showed that in a, in same similar situations in hospitals, in, in clinics, whether it's fractures, whether it's a variety of, of traumatic type things, but there's a hug body of data out that, that says people are actually leaving Emergency Rooms and hospitals inadequately treated for their pain.

MS. BROCATO: Because there's no treatment.

MS. KATZ: You bring up a very important point. That the undertreatment of pain is a very significant problem, particularly for the Medicaid population. And if we are going to put in places a lot of structures, is that going to exacerbate the problem? Because undertreatment -- I mean, it's a prosecutable issue.

MS. BETHMAN: Mm-hmm.

MS. KATZ: At this point it's a prossecution issue.

MS. BETHMAN: Exactly.

JUDGE FADER: Do we have any data information, suspicion or anything that the undertreatment of pain in Emergency Rooms and different places is as a result of a fear of prosecution?

DR. WOLF: There's data that shows that. There's also data that shows that some of the patients that are actually given access to medication, patients will tend -- in an acute pain situation, not in a chronic or an addiction, an addiction situation, but in an acute pain situation -- patients will balance the side effects versus the, their relief.

So if you ask them, or if you actually put them in the position of deciding whether they want better pain relief, but nausea and vomiting, they will take less pain relief and take less of the pills so that they can avoid the nausea, vomiting, the constipation whatever it happens to be. And there varying statistics based on the different side effect profiles.

That creates two different scenarios. One is the patient did get adequate medication, and then last

it at home and doesn't take it, and it sits in the medicine cabinet and it's available for, you know, whoever kind of walks by. And they need to be educated on what to do with that. There also needs to be a uniform means of us being able to advise the patients how to get rid of it. We're not allowed to tell them to flush it down the toilet anymore and that is one aspect that needs --

JUDGE FADER: Why aren't you allowed to tell them to flush down the toilet anymore?

DR. WOLF: Because it would end up in the bay.

JUDGE FADER: Oh, okay.

DR. WOLF: I winds up in the water supply.

JUDGE FADER: Should have thought of that.

MS. BETHMAN: Judge Fader --

MR. CLARK: Not green.

JUDGE FADER: Should have thought of that. Wasn't thinking.

MR. CLARK: Absolutely.

JUDGE FADER: Okay.

DR. WOLF: The other -- okay -- the other scenario that it, that arises is that, for the most part, patients will have, you know, this, this sense of balance, but in a lot of instances they're not being offered that opportunity to determine, you know, what,

whether or not they can have adequate pain relief. And, so, the, part of it is because of the chilling effect. And there, there's tons of data. I'm going to send you the program.

JUDGE FADER: Well, the next presentation here, Bob and I are going to meet and we're going to ask Ann and you, who are on the committee, to meet with us, the Committee, for data collection soon to help. Hope that presentation can be on April the 17th. But I'll talk to you --

DR. WOLF: Okay.

JUDGE FADER: -- about that. Bob and I are going to have lunch, and then get together with you and Ann to get together for lunch and, breakfast or whatever, to talk about this.

DR. WOLF: Okay.

DR. MARTIN-DAVIS: And, Judge, if I could just piggyback. You were asking whether or not there's data. I would think that like Marcia was saying, there probably is a lot of it out there. But I know one of the things hanging -- and I, perhaps, in Bowie, so I, I see patients in Anne Arundel Medical Center or North Arundel or Baltimore-Washington, and my patients who I, I have a contract with -- and it says you're taking narcotics with me -- you can't get them in the ER. You

know, if you do, you have to let me know they're going to the ER, for whatever reason, and saying I have a pain management drug. Will you -- this is what is going on now. I have a patient coming in yesterday with a letter, and I've seen more than one that says from this point forward, unless you bring in something written, or unless your, your pain management doctor calls us we, will not give you any narcotics.

Okay. Now, this happened to be a gentleman that has cyclic nausea and vomiting and abdominal pain, and he is one of my legitimate patients. They would not give him any pain medicine.

JUDGE FADER: They being who?

DR. MARTIN-DAVIS: They being Emergency Room.

DR. WOLF: Emergency Room.

JUDGE FADER: Emergency Room.

MS. MARTIN-DAVIS: Okay. Granted, he'd been in a number of times because he's still having problems with this. But for them to put in writing you cannot have any more narcotics because you have a pain management doctor, and unless she calls me or sends you with a note from mommy saying, yes, it's okay to give him medication, which you can't do that, because that's the case then, you know --

DR. FARAH: Then you have --

JUDGE FADER: Well, I will tell you that is insurance company-driven, because there are many suits across the United States, and many more have been successful, suing physicians, pharmacies, individuals because people became addicted. And a lot of the insurance companies are really getting upset and driving some of this stuff. We will talk to you about that and look into it; okay?

DR. MARTIN-DAVIS: (Nodding head yes.)

JUDGE FADER: But I would bet it is insurance company-driven.

MS. TAYLOR: I saw a hand all the way in the back.

JUDGE FADER: Anybody else? Mr. Shellenberger told me before he left that he certainly expects to be back here when we assemble more information that would have more questions for him. And I know the rest of you, I presume, would feel the same way. So we would hope that maybe July, or August or September to get you back here to a point where we could get your assistance, and input and questions that you may have.

Now, thank you, very much. We're going to be talking with everyone. I now just have a few things to try to clean up with the Council members. We're trying to do this in a meeting every six weeks. We have

pretty much of a full meeting on February the 27th. I think Joe Curran is going to come with John Howard from the Attorney General's Office.

You have someone; who is that LaRai?

MS. FORREST: I'm attempting and I think I'll be able to succeed getting Ralph Orr, and especially -- Agent's name is Larry Finley from Virginia --

JUDGE FADER: From --

MS. FORREST: -- to discuss the drug monitoring program.

JUDGE FADER: Mr. Keech is going to sit down with Bob Gilbert, who is acting with regard to the Attorney General's Office for the Prosecutors Division and tell him what happened in this meeting, and they're all going to confer with J.B. Howard, who is the Deputy Attorney General and see what else they want to say.

Once you're here you're on the list, which means that we're sending you all e-mails about everything. And that means you're invited to come and tell us anything you want to tell us about everything. Are Fridays pretty good? We've had someone that said that they would like to hold meetings in the evening because they are so busy. That has been my -- I just see a number of heads going back and forth, that they can't do that. It just seems to me that if we can hold

these things to three hours so that you can get back to the office, clean up what you need to clean up on Saturday, or Friday to prepare for Monday, that that's probably going to be the best. And I, I don't even have money for parking; okay? And it was insulting that we had to ask some people to pay to park in the State Office Building the last time. So all of these things we're hoping -- did everybody hear me say we need money? And, I mean, seriously, just a few hundred dollars here and a few -- if you know anybody that can do that, then we'll arrange through Secretary Colmer's Office as to how that needs to be done --

UNIDENTIFIED WOMAN: Makes sense.

JUDGE FADER: -- so we can have a fund so you have, you have money.

MS. ZOLTANI: Rats. No. I have a space for free parking.

JUDGE FADER: But Georgette is working on, trying to do the the best we can.

So is everybody satisfied with every six weeks? I wish we could accommodate everybody, but we're not going to be able to do it. As I said, next time we have here -- too many -- anybody come back to say as a result, anything has occurred as a result of this. And for the Federal people and the DEA, also,

the 27th, or the 17th of April, 17th of April. The week before that is Passover and Good Friday, so we would be after those holidays. On the 17th of April, Bob Lyles and company, we anticipate all of you who are on the Committee with regard to the data are going to tell us as much as you can in that period. Does anybody have any suggestions where we should go from there?

MS. FORREST: Well, I been in touch with -- I think I say his name wrong every time -- Mr. Hicclio (phonetically) in New York --

JUDGE FADER: Mm-hmm.

MS. FORREST: -- who is, I believe, in charge of the Alliance for the Creation, these sorts of programs, and he indicated he'd be very much interested in coming down, and talking with us, and giving us the pros and cons of how, how these programs work. And he is funded, so we wouldn't have to pay for anything.

JUDGE FADER: And he's with the Alliance for the Creation, okay. Well, then, maybe, maybe next week you and I can talk about that and we can aim for him, maybe in June, or something of that sort.

Okay. And then, in the meantime, we're trying to assemble the data from the various states, and everybody is going to chip in, do a little bit here.

It seems to me the Alliance person would be the best person to talk to start that off. So I'll give you a call next week --

MS. FORREST: Okay

JUDGE FADER: -- and we'll, we'll talk about that.

Anybody else? Georgette, what else do you want me to --

MS. ZOLTANI: Well, I'm looking for data from the State of Maryland for prescription drug abuse. If anybody has any, be really important, 'cause we need it for the grant.

JUDGE FADER: All right. Now, just to say, too, what you will get from me is, eventually you will get a copy, electronically, of this transcript, a separate paper that will say these were the questions that were brought up and then you will also get a list of every handout that you had, and it'll -- and we'll put those in PDF format and send them to you, also; okay?

But that's about as much as I can accomplish through all of this. Anybody have anything else they want to say -- it's just nice to be in beautiful downtown Columbia or something?

MS. ZOLTANI: The next meeting we have this

room for the 27th, if that's okay with everybody.

MR. CLARK: Mm-hmm. A good spot.

JUDGE FADER: Okay. Is that all right?

AUDIENCE: Yes.

JUDGE FADER: Okay. February the --

MS. ZOLTANI: The 27th.

JUDGE FADER: -- 27th we'll be here, hopefully with coffee and donuts. We will see. Okay. Thank you.

DR. WOLF: And no donuts. It ruins our diets.

JUDGE FADER: Notice three and a quarter hours.

MR. KEECH: And, with that, the meeting's adjourned, right?

THE REPORTER: (Nodding head yes.)

JUDGE FADER: Thank you, so much.

(Meeting adjourned.)